PRINTED: 05/18/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL		2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	00,2	0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS		A	000			
	a result of a Medicare conducted in your fact through September 2 The following Condition of met: 42 CFR 482.12 Gove 42 CFR 482.13 Patie 42 CFR 482.21 Qualification of the findings and comby the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws. The following regulate identified.	rning Body nt's Rights narge Planning ty Assessment and ement clusions of any investigation n shall not be construed as al or civil investigations, is for relief that may be under applicable federal, ory deficiencies were					
A 043	body legally responsi hospital as an institut have an organized go legally responsible for must carry out the furthat pertain to the go. This CONDITION is Based on policy and interview, the facility governing body was legally as an interview of the second interview.	ve an effective governing ble for the conduct of the ion. If a hospital does not overning body, the persons or the conduct of the hospital notions specified in this part overning body. In the tas evidenced by: procedure review and staff failed to ensure an effective egally responsible for the		043			
I ABORATORY	-	al. The facility failed to SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 043	(A-0115); failed to de maintain an effective data-driven quality as improvement prograr ensure an effective d that applies to all pat policies and procedu (A-799). The facility failed to describe the failing to ensure a contract were provided manner (A0084); and staff had written policies and written policies appraisal of emergent referral when needed. The cumulative effect resulted in the failure statutory mandated of 482.12(e)(1) CONTR. The governing body is services performed upon a safe and effective this STANDARD is Based on review of operformance improve and interviews with the facility's governing body and interviews with the facility's governing body and interviews with the facility's governing body and interviews with the facility's governing body.	each patient 's rights velop, implement and , ongoing, hospital-wide, seessment and performance in (A-263); and failed to ischarge planning process ients was in place and the res were specified in writing comply with Federal er the Condition of erning Body as evidenced by: services performed under ed in a safe and effective I failing to assure medical cies and procedures for icies, initial treatment, and I (A0093). It of these systemic practices of the facility to deliver hare to patients. ACTED SERVICES must ensure that the inder a contract are provided the manner. Inot met as evidenced by: uality assurance tement (QAPI) documentation ine Hospital Administrator, the ody failed to ensure services act were provided in a safe		043			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE .AS VEGAS, NV 89119	·	
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A 093	performance improve that contracted service QAPI program. In an interview with the 9/26/08 at 1:30 PM, the hospital did not in the QAPI program. The twith the contract quarterly. The Admir assurance information contractors yearly but information available 482.12(f)(2) EMERG If emergency service hospital, the governimedical staff has write for appraisal of emergency and referral when apolicies for appraisal treatment and referral emergencies and fail responsibilities in an involving persons where identical the governing develop written policies.	s quality assessment and ement program did not reveal ces were included in the me Hospital Administrator on the Administrator reported include contracted services in The Administrator stated he ed services representatives instrator reviewed quality in provided by the tidd not have a record of the in the facility. ENCY SERVICES Is are not provided at the ing body must assure that the ten policies and procedures gencies, initial treatment, propriate. Inot met as evidenced by: Body bylaws, medical occedure review and staff failed to develop written of emergencies, initial I of persons with ed to train staff as to their	A 084			

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WING _		09/:	09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	S	TREET ADDRESS, CITY, STATE, ZIP CODI 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•		
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A 093	the emergency care the hospital was add address emergency seeking help at the hat the facility (staff, v 3. On 9/23/08 at 10:0 was interviewed. Ch what she would do if unresponsive on the stated she would call would do anything el she would rot. Charg she would call a code respirations and the would not because s and the medications 4. On 9/23/08 at 10:2 Licensed Practical N were interviewed. The question regarding the visitor without a pulse reported they would signs and do cardiop needed. The staff all code but would call sambulance responded the staff did not know addressing emergen persons seeking emergen persons seeking emergen.	edical staff bylaws revealed of patients and residents at ressed but the bylaws did not care provided to people ospital who were not patients isitors etc.). O AM, Charge Nurse #12 arge Nurse #12 was asked a visitor collapsed and was unit. Charge Nurse #12 I 911. When asked if she se, the Charge Nurse stated ge Nurse #12 was asked if eif there was no pulse or Charge Nurse said she he did not know the person the person was taking. O AM, Charge Nurse #9, urse (LPN) #10 and LPN #11 he staff were asked the same he care of an unresponsive er or respirations. The staff assess the person, take vital fullmonary resuscitation if a lagreed they would not call a lagre	A 09	3			
	Nursing (DON) was a and procedure addre	00 AM, the Acting Director of asked for the facility's policy essing emergency care of esons seeking emergency					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		290042	B. WIN	IG		09/26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 093	policy and procedure that addressed only emergency care. En staff and persons se assistance was not a procedure. 6. The hospital admi policy and procedure Medical Treatment & Compliance". The poit was originated on a that any person pres requesting assistance condition would be en Nurse. There was not contact a physician. To be provided within abilities until approprimate to transfer the room. The Acting DON was procedure "Emergent Active Labor Act (EN PM. The Acting DOI the policy before. The policy "pretty much" and reported the state once. The Acting DOI staff nurses did not be provide emergency of patients or residents. On 9/23/08 at 2:00 F was interviewed. The	The Acting DON submitted a entitled "Emergency - 911" patient and resident mergency care of visitors, eking emergency medical addressed in the policy and mistrator submitted a second entitled "Emergency Active Labor Act (EMTALA) policy and procedure revealed 4/08. The policy revealed enting to the hospital efor a potential emergency valuated by a Registered or indication the nurse was to Emergency assistance was the scope of the hospital's riate arrangements could be person to an emergency as shown the policy and acy Medical Treatment & (TALA) Compliance" at 1:00 N stated she had never seen the Acting DON stated the described what the facility did for an a code on a visitor DN could not explain why the stook of their responsibility to care to people who were not of the facility. PM, the Director of Education were seen the policy and	A	093			

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		290042	B. WIN	G		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE S VEGAS, NV 89119		
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A 093	•	abor Act (EMTALA) rector of Education reported ceive training in the policy g orientation or as an	A	093			
A 115	A hospital must prote patient's rights. This CONDITION is	ect and promote each not met as evidenced by:	A	115			
	review, the facility fai each patient's rights. each patient whom to (A-0118); failed to en included a mechanism patient concerns regapremature discharge and Quality Control (Organization (A0120 explained procedure patient's written or vehospital (A-0121); fail process specified time grievance and the procedure patient's written or vehospital (A-0122); failed to provide and the hospital taken on behalf of the grievance, the results and the date of compensure the patient had the development and plan of care (A-0130); the patient had the rights or her clinical recensure all patients had); failed to establish a clearly for the submission of a					

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NAME OF PR	OVIDER OR SUPPLIER	2000-2	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/2	26/2008	
HARMON	MEDICAL AND REHABI	LITATION HOSPITAL	2	170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
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A 115	retaliation by staff. Reconly be imposed to ephysical safety of the others and must be depossible time (A-015-cor seclusion may only restrictive intervention be ineffective to protemember, or others from the ensure the type or tesseclusion used must intervention that will be patient, a staff member (A-0165); failed to ensure order seclusion must be in modification to the patient to ensure order or on an as nearly and the ensure the arestrictive intervention documented in the patient of the ensure that the	estraint or seclusion may insure the immediate patient, a staff member, or iscontinued at the earliest 4); failed to ensure restraints or be used when less ins have been determined to ect the patient, a staff orm harm (A-0164); failed to chnique of restraint or be the least restrictive one effective to protect the er, or others from harm sure the use of restraints or accordance with a written attent's plan of care (A-0166); is for the use of restraints or the written as a standing eded basis (PRN) (A-0169); liternatives or other less ins attempted have been attent's medical record sure the patient has the right on of restraint or seclusion by and failed to ensure the ins associated with the use of these systemic the failure of the facility to dated care to patients. T RIGHTS: GRIEVANCES	A 115				
	resolution of patient geach patient whom to	tablish a process for prompt grievances and must inform o contact to file a grievance.					
	0 17 11 107 11 10	not mot do ovidoriood by.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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A 118	Based on interview a hospital failed to esta resolution of patient of failed to inform each file a grievance. Findings include: 1. A review of the griever	evance policy titled: "Social Complaint Process policy 6." There were no further red. The policy did not include how ned of the procedure or to be the grievance. The policy titled: "Social Complaint Process policy 6." There were no further red. The not addressed in the expolicy did not include how ned of the procedure or to be the grievance. The policy titled: "Social Complaint Process policy 6", stated: "5Leadership description of the gal rightsB. written go the facility's staff members rievance/Complaint The policy field in section B (as as unable to be produced as unable to be produced or med of hospital policies at to be informed of available and disputes, grievances, and ics committees, patient	A 118			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	ILITATION HOSPITAL	1	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	, , ,		
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A 118	Continued From pag	ne 8	A	118				
A 120	Hospital" did not cor grievance process s grievance. 4. On 9/23/08 in the the Acting Director of Worker (SW), confirmed the admissions on the subject. 5. On 9/24/08 in the the SW, confirmed the Faction of the subject. 5. On 9/24/08 in the the SW, confirmed the pating the subject. The hospital must be resolution of patient each patient whom to the thospital must be resolution of patient each patient whom to the hospital's governous process, a grievance process, a grievance process, a grievance process in writing to a grieval grievance process in timely referral of pating the pating the pating the properties and properties utilization the process of the process of the pating the process of the pating the process of the process of the pating the process of t	stablish a process for prompt grievances and must inform o contact to file a grievance. ning body must approve and it is effective operation of the and must review and resolve to delegates the responsibility ince committee.] The must include a mechanism for itent concerns regarding emature discharge to the on and Quality Control Quality ization. At a minimum:	A	1200				
	Based on interview a failed ensure the grid	not met as evidenced by: and policy review, the facility evance policy contained a y referral of patient concerns						

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	OVIDER OR SUPPLIER	LITATION HOSPITAL	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	·	
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A 120	to the appropriate Ut Quality Improvement Findings include: 1. The "Social Service Process policy SS-82 updates were provide revealed specific time Utilization and Qualit Improvement Organithe grievance policy. The patient's "Bill of the hospital's "Admis Packet" contained in file a complaint. The phone numbers to the provided; the State SAgency, State Ombut Protection and Advoc Disabled Individuals, and the Anvestigating Medical information provided Control/Quality Improduced Control/Quality Improduced Control (SW), confirm (as discussed above (given to the patient all the facility had on On 9/24/08 in the mod SW, confirmed there	are or premature discharge dilization and Quality Control organization. The Grievance/Complaint organization organization. The Grievance/Complaint organization organization. The Grievance/Complaint organization of the organization organization organization organization. The Grievance/Complaint organization organization organization organization. The Grievance/Complaint organization organization organization. The Grievance/Complaint organization organization organization organization.	A 120			

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A 120	Continued From page	e 10	A	120			
	and to whom to file a	grievance.					
A 121	frame established for SW confirmed there vinformation, explaining the patients.	ere was no specific time the grievance process. The was no written grievance g the process, available for ENT RIGHTS: GRIEVANCE	A	121			
		tablish a clearly explained omission of a patient's written o the hospital.					
	Based on interview a hospital failed to esta	not met as evidenced by: nd document review, the blish a clearly explained emission of a patient's written to the hospital.					
	Findings include:						
		Process policy SS-82 not address specific timelines					
		lude how the patient was dure or to whom they were					
	furnish a written desc patient's/resident's le	gal rightsB. written g the facility's staff members					

NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL (X41)D (X41)D (R41)D (R42)D (R42		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL (X4).D. SUMMARY STATEMENT OR DEPOSITIONS (GRAND NORTHOLOW) SUMMARY STATEMENT OR DEPOSITIONS (GRAND CROTHEONY MUST BE REDECEDED by FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 121 Continued From page 11 The written information specified in section B (above) was unable to be produced during the survey. 2. The "Admission Business/Insurance Packet Hospital" contained a "Bill of Rights" that stated "12nght to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available" The "Admission Business/Insurance Packet Hospital" did not contain information detailing the grievance process specifying with whom to file a grievance. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, confirmed there was no process in place for ensuring the patients were made aware of how and to whom to file a grievance information available for the patients. A 122 A 122 A 122			290042	B. WIN	G		09/2	6/2008
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			LITATION HOSPITAL	'	2	170 EAST HARMON AVENUE	30/2	5/ 2 000
The written information specified in section B (above) was unable to be produced during the survey. 2. The "Admission Business/Insurance Packet Hospital" contained a "Bill of Rights" that stated "12right to be informed of hospital policies and proceduresright to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available" The "Admission Business/Insurance Packet Hospital" did not contain information detailing the grievance process specifying with whom to file a grievance. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, confirmed there was no process in place for ensuring the patients were made aware of how and to whom to file a grievance. The SW confirmed there was no written grievance information available for the patients. A 122 A 212	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response.		The written information (above) was unable to survey. 2. The "Admission But Hospital" contained a "12right to be information proceduresright to be resources for resolving conflicts, such as eth representatives, or of available" The "Admission Busing Hospital" did not conting grievance process sparievance. On 9/23/08 in the money Acting Director of Nur Worker (SW), confirmant the admissions proon the subject. On 9/24/08 in the money SW, confirmed the ensuring the patients and to whom to file a survey and the subject of the subject of the subject of the survey and the subject of the survey and the subject of the survey of the grievance for review of the grievance for review of the grievance of the survey of the grievance of the survey of the grievance of the grieva	on specified in section B to be produced during the desires siness/Insurance Packet "Bill of Rights" that stated and of hospital policies and be informed of available and desires, grievances, and acs committees, patient ther mechanisms The same of the sines of the same of the sines of the same of the sam					

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A 122	This STANDARD is Based on interview a hospital failed to estatime frames for review provide a response to Findings include: 1. A review of the "So Grievance/Complaint Original 3/2006", did for reviewing the grie complainant. The policy did not include was informed of the complainant on 9/23/08 in the mo Acting Director of Nut Worker (SW), confirm	not met as evidenced by: nd document review, the blish a process specifying w of the grievance and to the complainant.	A 12	· ·		
A 123	SW, indicated there we provide a response to of the grievance. 482.13(a)(2)(iii) PATI GRIEVANCE DECIS At a minimum: In its resolution of the must provide the pati decision that contains contact person, the s	e grievance, the hospital ent with written notice of its s the name of the hospital teps taken on behalf of the the grievance, the results of	A 12	23		

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A 123	Based on interview a facility failed to ensure decision containing the contact person, the sepatient to investigate the grievance process investigation complete patient. Findings include: 1. A review of the "So Grievance/Complaint Original 3/2006", did patient was informed grievance. The policy did not adwritten notice of grievance of grievance of the admissions processing the subject. On 9/24/08 in the modern of the subject. On 9/24/08 in the modern of the grievance of th	not met as evidenced by: and document review, the re a written notice of its the name of the hospital steps taken on behalf of the the grievance, the results of is, and the date of tion was provided to the cocial Services t Process policy SS-82 not include if or how the of the outcome of the dress the patient receipt of a vance outcome. coming, an interview with the rring (DON) and Social med the policy on grievances bracket was all the facility had coming, an interview with the was no process in place to conse to the patient of the ance. IT RIGHTS:PARTICIPATION ight to participate in the colementation of his or her	A 130			
	This STANDARD is	not met as evidenced by:				

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		290042	B. WING		09	/26/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL	217	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE S VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 130	Based on interview a facility failed to ensuright to participate in implementation of the Findings include: 1. The Patient's "Bill patient has the right plan of care prior to treatment and to refet treatment or plan of by law and hospital medical consequent such refusal, the parappropriate care and provides or transfer hospital should notif might affect patient appropriate care and provides or transfer hospital should notif might affect patient appropriate care and provides or transfer hospital should notif might affect patient appropriate care and provides or transfer hospital should notif might affect patient appropriate care and provides or transfer hospital should notif might affect patient affect patient are initiated upon admission. Care plans are to be Nurse's Station and condition changes. Or review of care by initial times must be reare resolvable. Upon patient dischal completed and filed being sent to the He (Medical Records Diccinical Directors will Management Section).	and document review, the are the patients exercised their the development and their plan of care. of Rights" stated "3. The to make decisions about the and during the course of use a recommended care to the extent permitted policy and to be informed of the ses of this action. In case of the services that the hospital to another hospital. The y patients of any policy that choice within the institution" Plan Policy 341km (issued 4/07)" stated: "Care Plans a patient by the Registered d to admit them. These are sion or no later than 24-hours are maintained in a binder at the are updated as patient's Charge RN, will acknowledge tialing in the indicated section. Solved by discharge, if they are, Care Plans must be in the Medical Record before alth Information Department epartment).	A 130			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI				
		290042	B. WIN	IG		09/20	6/2008
	OVIDER OR SUPPLIER MEDICAL AND REHABII	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 130	Continued From page	e 15	A	130			
A 147	Nursing (DON) indica care plan. The Acting and/or family was not process.	M, the Acting Director of steed the nurse completes the g DON indicated the patient involved in the care plan		147			
A 147	482.13(d)(1) PATIEN CONFIDENTIALITY (A	147			
	The patient has the ri	ght to the confidentiality of ords.					
	Based on observation	not met as evidenced by: n and staff interview, the of the privacy of patients for 0, #14).					
	Findings include:						
	facility on 8/28/08, with	ent was admitted to the th diagnoses that included Failure, Anxiety State and					
	was observed on the The photograph was the counter top. The p were clearly visible in patient's name was w	raph of Patient #9's buttocks nurses station counter top. one of four photographs on patient's buttocks and ulcers the photograph. The written in large letters that from several feet away.					
	on 9/24/08. WCN #1 photograph where pa	WCN) #13 was interviewed 3 was told he had left the ssersby could see them. he had made a mistake in ient's privacy.					
	Patient #14: The pati	ient was admitted to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 154	Paraplegia, Myopath #14 was noted to have admission to the hose of	th diagnoses that included y and Dysphagia. Patient we a decubitus ulcer on pital. graph of Patient #14's sacral on the nurses station counter was one of four counter top. The patient's ly seen by people walking by the patient's name was prograph and could be easily get away. #13 was interviewed on was told he had left the assersby could see them. If he had made a mistake in tient's privacy testraint or Seclusion. All to be free from physical or proporal punishment. All to be free from restraint or m, imposed as a means of convenience, or retaliation by clusion may only be imposed interphysical safety of the per, or others and must be arliest possible time.		154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	217	ET ADDRESS, CITY, STATE, ZIP CODE O EAST HARMON AVENUE S VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
A 154	and discharged on 1/2 including Pneumonia Other Mental Condition 1. Restraint Orders - 12/29/07; time 10:0 Vest; reason: trying to fall 12/31/07; time 0700 (hr); type PV (Posey bed no safety awaren - 12/30/07; time 0700; reason: climbs out of - 1/8/08; time 0700; reason: climbs out of - 1/8/08; time 0700; reason: climbs out of - 1/12/08; time 0800 type Posey vest; reasbed without assistanc - 1/16/08; time 0800; reason: attempts to gassistance, fall precason: attempts to gassista	ted to the facility on 12/28/07 /16/08 with diagnoses; Hypertension; Debility; and on 5; duration 24 hour; type o get out of bed/hx (history) 0 (7:00AM); duration 24 hour vest); reason: climbs out of ness. 0; duration 24 hr; type climbs out of bed no safety duration 24 hr; type PV; bed no safety awareness. duration 24 hr; type PV; bed no safety awareness (8:00AM); duration 24 hr; son: attempts to get out of ce, fall precautions. duration 24 hr; type PV; get out of bed without nutions. ed in the policy (Titled: Procedures, Restraint, Re - 5 through 12) were not d. The forms were the seessment, Physical Restraint Chart Checklist, estraint Use, Interdisciplinary Restraint, and the Restraint og.	A 154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL		21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	1 00/2	0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I .	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 154	evidence less restrict alternatives were trie 4. The record containe vidence reassessmerestraints was compleremoval and repositions. 5. The care plans were the use of restraints. 6. There was no concuse of restraints, in the Patient #28 was admited with diagnoses included Depressive Disorder; State; Other Chronic Hypertension; Debilit Condition 1. Physician's Order: An order was written "Posey Vest for pts' (The policies and processive Disorder: The Pink Physical Fit to be placed on the pink Physical Fit of the policies and processive Disorder: The Pink Physical Fit of the pink Physical Fit of the placed on the pink Physical Fit of t	ive measures and d. med no documented ent to terminate the eted during the 2 hour oning period. ere not updated to include sent forms, authorizing the ne record. itted to the facility on 9/17/08 ling Altered Mental State; Hypertension; Anxiety Pain; Pneumonia, y; and Other Mental s: on 9/23/08 at 0800 (8 AM), patient's) safety." cedures, listed below, Restraint Order Sticker was hysician's order sheet. t an acceptable rational for fications of duration.	A	154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		290042	B. WIN	G		09/2	6/2008		
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL		2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE S VEGAS, NV 89119	, 30,2	3, 2 333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT FIX (EACH CORRECTIVE ACTION SHOU G CROSS-REFERENCED TO THE APPRO DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
A 154	original: 3/2006; NP in the patient's record Physical Restraint As Restraint Follow-Up, Informed Consent Re Care Plan Physical R Tracking/Trending Los Trending Los Trending Period: 1200 (noon); 1400 (2 PM); 2000 (8 PM); ar The "Restraints" port Care Record" indicate hour intervals. There made in this section: A. "Pt (patient) attem unsteady gait"; and B. "2000 (8 PM) pt a unsteady gait". The "Patient Care No The Tracking Trending Trending Patient With Posey Version Trending T	R - 5 through 12) were not I. The forms were the sessment, Physical Restraint Chart Checklist, estraint Use, Interdisciplinary estraint, and the Restraint Ig. led no documented evidence ares and alternatives were led no documented evidence are and losso (AM); 1000 (10 AM); PM); 1600 (4 PM); 1800 (6 and 2200 (10 PM). Ion of the 9/24/08 "Patient led staff initialed off at eight 2 are were only 2 written entries are puts to get out of bed, lettempts to get out of bed, lettempts to get out of bed, lettes" portion were recorded attent is awake, alert with no les any pain or discomfort. Lest on for safety." The not updated to include the lessent forms in the record,	A	154					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/	26/2008	
	ROVIDER OR SUPPLIER	BILITATION HOSPITAL	·	2170	T ADDRESS, CITY, STATE, ZIP CODE BEAST HARMON AVENUE BVEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 154	with diagnoses inclicated Cardiomyopathy; E. Hypoxemia 1. Restraint orders - 9/25/08; time 0800 type: B (bilateral) so pulling out tubes 9/25/08; time 0900 type: wrist restraints (peripherally inserted for fall. 2. The "Restraints" Care Record" indicated hour intervals (0200 0600 - 6 AM). There of the control of the patient's recording policies and original: 3/2006; Ni in the patient's recording policies. The patient's recording and the patient's recording policies and original: 3/2006; Ni in the patient's recording policies. Tracking/Trending I. Tracking/Trending I. The record contate vidence less restrial ternatives were tracking-track	mitted to the facility on 9/17/08 uding Pleural Effusion; dema; Atrial Fibrillation; and 0 (8:00AM); duration 24 hr; oft wrist restraints; reason: 0 (9:00AM); duration 24 hr; s; reason: pulls out PICC ed central catheter) line, risk portion of the 9/24/08 "Patient ated staff initialed off at three 2 0 - 2 AM; 0400 - 4 AM; and e were 3 unreadable entries. fied in the policy (Titled: d Procedures, Restraint, 0 - R - 5 through 12) were not rd. The forms were the assessment, Physical o, Restraint Chart Checklist, Restraint Use, Interdisciplinary Restraint, and the Restraint Log. ained no documented ctive measures and ed. ained no documented ment to terminate the oleted during the 2 hour	A	154				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING _		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL		REET ADDRESS, CITY, STATE, ZIP COD 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 154	plans in the patient's an unidentified emplorate plan available for the plant of th	PM, there were no care record. Employee #22 and byee confirmed there was no or Patient #29. Insent forms in the record, for restraints. Insent forms in the record, for restraints at approximate set of the restraints. Insent forms in the record, for eason in the record, for the restraints at approximately recause the patient was Insent forms in the record, for eason set on the record, for the restraints at approximately recause the patient was Insent forms in the record, for eason set on the record, for the restraints at approximately recause the patient was Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason should not negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restraints. Insent forms in the record, for eason's pulls out negroid the restr	A 154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN			09/:	26/2008	
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL		2170	ADDRESS, CITY, STATE, ZIP CODE EAST HARMON AVENUE VEGAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 154	Care Record" indica of 2 hour intervals (CAM). The written en bilateral wrist restrai and when family me for circulation, hydra pulses of upper extr. B. six entries were circulation." The "Patient Care NA. 1430 (2:30 PM)" bilateral restraints, a 3. The "Restraints" Care Record" indica of 2 hour intervals (CAM). There were 2 A. "Patient bilateral every 2 hours or whethe patient. Restrain pulse present, no re Patient given ice chi B. "Bilateral wrist retube. Checked restriceleased at times for The "Patient Care NA. 1200 (noon)"pa Bilateral wrist restramonitors the patient B. "1400 (2 PM) patisupervises bilateral 4. The "Restraints" Care Record" indica hour intervals (0800	portion of the 9/19/08 "Patient ted staff initialed off 24 hours 1800 - AM through 0600 - tries included: A. "Patient nts released every 2 hours mber supervises the patient tion, redness noted, all emities present; and all recorded as "Checked otes" portion recorded:checked for circulation in II pulses present." portion of the 9/21/08 "Patient ted staff initialed off 24 hours 1800 - 8 AM through 0600 - written entries: wrist restraints removed en family member supervises atts removed for circulation all dness or edema noted. ps, oral done frequently"; and straints on patient pulled ng taints q (every) 2 hours or circulation." otes" portion recorded: attent calm resting on the bed, ants removed, patient wife "; ent calm resting in bed wife	A	154				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	26/2008	
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	•	217	ET ADDRESS, CITY, STATE, ZIP CODE O EAST HARMON AVENUE S VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 154	restraints." The "Patient Care N -1900 (7 PM); "Place - 20 (8 PM); "Patie restraints on." 5. The forms specifi Nursing Policies and original: 3/2006; NP in the patient's recor Physical Restraint A Restraint Follow-Up, Informed Consent R Care Plan Physical I Tracking/Trending L 6. The record conta evidence less restric alternatives were tried. 7. There were no contact authorizing the use of restraint. The facility presente use of restraint. The hospital did not accrediting body app Medicare and Medicare and Medicare Hospital C Patient Rights; and the references used Medicare Hospital C Patient Rights; and the reference in the reference	otes" portion recorded: ed on both wrist restraints" ent on bilateral soft wrist ded in the policy (Titled: I Procedures, Restraint, P - R - 5 through 12) were not d. The forms were the ssessment, Physical I Restraint Chart Checklist, estraint Use, Interdisciplinary Restraint, and the Restraint og. ined no documented etive measures and ed. onsent forms in the record, of restraints. d five different policies on the have accreditation by an proved by the Centers for aid Services. y titled "Restraints" (undated on page 4 of the policy that to develop the policy was the onditions of Participation:	A	154				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE .AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 154	restrictive method the will be applied only a been attempted and (see Attachment A - alternatives i.e. diver communication skills measures must be d - on page 2, item 4 - documented" - on page 2, item 9 - accordance with an i modification to the calcolor on page 3 item 50 - Order Sticker is place sheet"	red the following: "The use of the least at meets the patient needs fter alternative methods have failed to meet patient needs A listed examples of sion activities, , environment). Alternative ocumented. "alternatives must be "The restraint order will be in mmediate written are plan, i.e., it will be used in response to a plan of care ified after the use of normal ed." "Pink Physical Restraint ed on the physician's order	A 154			
	For Safety is not act- on page 3, item 6b will reflect increased intervals to 1 hour intindicated" - on page 4, item 10 reassessment may putermination of restrait restraint before the titus assessment. The orwithin the 24 hour tin order if alternatives a is terminated early an evident." - on page 4, item 11 use and documentat	- "The patient's care plan monitoring from 2 hour tervals, as medically - "Monitoring and ermit the reduction or early nt. Staff may release				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	S	STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	i	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 154	be ineffective. Care possible after the resappropriate and necesaddress the frequence on page 8, item 8 - is discussed with the whenever possible arrequiring the need for behavioral condition and the patient's und. 2. The facility policy 309km, Restraint Prowith the most current approval signatures volumented of the page 2 item policy 309km, Restraint Prowith the most current approval signatures volumented of the page 2 item policy 309km, Restraint Prowith the most current approval signatures volumented only a been attempted and the sense of the page 2 item policy 40 continuous, and alter documented" - page 2 item 5a - "a must assess the patient of the page 2 item 5b - "Pi Sticker is placed on the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 2 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 3 item 5e - "Resafety is not accepta page 3, item 8 - "the discussed with the page 3e - item 5e - ite	have been tried and found to clans are updated as soon as traint has been determined issary. The care plan will by and monitoring" "the possible use of restraint patient and/or family and include behaviors restraint and what resulting in restraint removal erstanding of the same." Ititled "Nursing Services, cedure, 4 pages dated 7/93 revision dated 12/06, were dated 1/2/07 and the following: Is - "The use of the least at meets the patient needs fter alternative methods have failed to meet patient needs A listed examples of sion activities, environment). Alternative boumented." Is - "Initial assessment, matives must be an RN (Registered Nurse) ent daily to determine the mk Physical Restraint Order the physician's order sheet" The asson for the restraintFor	A 15	<u>j4</u>		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 154	resulting in restraint understanding of the page 3, item 11 - ". restraint use and do monitoring and care. updated only after rebeen tried and found are updated as soon restraint has been denecessary." 3. The facility policy 309gf, Restraint Prowith the most current approval signatures documented the following Services, 3 4. The facility policy Procedures, Restraint 5 through 12" documented unless the facil (IDT) has completed evaluation to identify environmental factor restrictive alternative Emergency is define behavior threatens here are some process.	t behavioral condition removal and the patient's same." .Plan of Care addresses cumentation of ongoing Care plans are to be straint alternatives have to be ineffective. Care plans as possible after the etermined appropriate and titled "Nursing Services, cedure, 5 pages dated 7/93 t revision dated 12/03, no were on the procedure" owing: the later approved version 09km, Restraint Procedure". titled "Nursing Policies and nt, original: 3/2006; NP - R - mented the following: cy 1 - "restraints will not be ity's Interdisciplinary Team	A	154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	'	217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE S VEGAS, NV 89119	, 30.2	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 154	the nurse completes establishes a plan, o updates the care plan plan." - Page R-5, item pro as soon as possible and consider if all althave been selected athe highest level of forestrictive measures. - Page R-6, item 4 - prior to consideration documented in the particular prior to consideration documented in the particular prior to consideration documented in the particular plans informed confamilyif the patient making." - Page R-6, item 7 - approaches in the particular proaches must incomprehease, and reposition approaches must incomprehease, and reposition proaches in the particular plans in the use of recomprehensive assetures. Page R-6, item 9 - warrant the use of recomprehensive assetures assetures assetures assetures. Page R-6, item 10 - plans indicate the neen gages in a system towards reducing resured: Physical Restraint; a Log.	a restraint assessment, praints an order, consent and in prior to implementing the cedures 2 - "The IDT meets to review the assessment, ternatives and interventions and implementedmaintain inctioning with the least " "All alternatives attempted of using restraint are attent's medical record." The facility is responsible for consent from the patient, lacks medical decision "Enter the problem, goal and tient's care plan. The lude frequent observation, on" Documentation of restraint tained in the medical Medical symptoms that estraints are reflected in the sament and care planning." "It is further expectedcare and for restraints the facility attic and gradual process traints." the sample forms to be raint Assessment; Follow-up; and Consent; Care Plan - and Tracking and Trending	A	154			
	1	itled "What You Need to ysteries of Restraints";					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 154	Restraint, original: 3 pages 4-5." - The items mirrored "Nursing Policies and original: 3/2006; NP 6. The instructions of the "Daily Patient Cathe timed box the participation of the "Daily Patient Cathe timed box the participation of the "Daily Patient Cathe timed box the participation of the "Daily Patient Cathe timed box the participation of the "Daily Patient Cathe timed box the participation of the "Daily Patient Cathe timed box the participation of the "Daily Patient" of the "Daily Patient" of Nursing) provided were the post of the "Daily Patient" of Nurses on Restrolic provided were the post of the Staff Developer training session 9/9/0 training the staff. 9. Interviews with Chen Nurses from each of on 9/25/08 beginning interviews revealed: - the staff had an idenot necessarily trained (Licensed Practical News trained by the face)	olicies and Procedures, /2006, Revision 3/2008; the later approved version of Procedures, Restraint, - R - 5". If the "Restraints" portion of re Record" read: "Initial in tient was checked for tion under the restraint and ation, nutrition, exercise and estraint on/off." afternoon, the Acting DON reported the policies officies utilized by the facility. morning, the Staff Developer tursing Policies and aints (refer to item #4 in dicated this restraint policy wanted the facility to utilize. The reported she just began (first 108 and the second 9/17/08) arge Nurses (RN) and Floor the 6 units were conducted at 10:30 AM. The a of restraint use, but were and at the facility, an LPN durse) could not recall if she cility, other staff remembered computer, one staff reported	A	154			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 154	trained however she the staff were unsured and were unawa the staff were unsurestraints and what to they were removed. The staff were kept is said restraints were kept in the unit. One RN is the wrist restraints are the staff were unsurfamily, some staff staff.	N) reported she was not could go to her supervisor. The of what the facility policy are of where it was located. The of where to obtain to do with the restraints when some staff thought and the supply room, others kept in the laundry, another ints that were kept on a cart stated she would throw away and Posey vests after use. The if they were to inform the steed they would call the	A	154			
A 164	restraint use. Most of would document on to one mentioned updated and the mentioned alternative measures 482.13(e)(2) PATIEN OR SECLUSION Restraint or seclusion less restrictive interved determined to be ineal a staff member, or of the second of the sec	ware of where to document of the RNs reported they he daily nursing notes. No ting the Care Plan. The deleast restrictive and prior to restraint application. THE RIGHTS: RESTRAINT The may only be used when tentions have been ffective to protect the patient, hers from harm. The motion met as evidenced by: document review and record the d	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE D VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETION DATE
A 164	Continued From pag	e 30	A	164			
A 164	Findings include: Patient #1 was admit and discharged on 1/2 including Pneumonia Other Mental Condition 1. Restraint Orders - 12/29/07; time 10:0 Vest; reason: trying to fall 12/31/07; time 0700 (hr); type PV (Posey bed no safety awarer - 12/30/07; time 0700 Posey vest; reason: climbs out of - 1/8/08; time 0700; reason: climbs out of - 1/12/08; time 0800 type Posey vest; reason: climbs out of - 1/16/08; time 0800; reason: attempts to gassistance, fall precason: The forms specification 2. The forms specification 2.	tted to the facility on 12/28/07 /16/08 with diagnoses r; Hypertension; Debility; and on 5; duration 24 hour; type o get out of bed/hx (history) 0 (7:00AM); duration 24 hour vest); reason: climbs out of ness. 0; duration 24 hr; type climbs out of bed no safety duration 24 hr; type PV; 5 bed no safety awareness. duration 24 hr; type PV; 5 bed no safety awareness (8:00AM); duration 24 hr; son: attempts to get out of ce, fall precautions. duration 24 hr; type PV; get out of bed without	A	164			
	original: 3/2006; NP in the patient's record Physical Restraint As Restraint Follow-Up, Informed Consent Re	- R - 5 through 12) were not d. The forms included ssessment, Physical Restraint Chart Checklist, estraint Use, Interdisciplinary Restraint, and Restraint					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	'	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	, 30.2	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 164	restraints was done of and repositioning pe 5. The care plans we the use of restraints. Patient #28 was admit with diagnoses included be pressive Disorder State; Other Chronic Hypertension; Debilit Condition 1. Physician's Order An order was written Vest for pts' (patient') There was no pink prespecified in the policible below: - "The Pink Physical placed on the physical "" - "There was no sport in the policible of the physical specified in the policible of the physical specified in the policible of the physical specified in the physical specified in the patient's recomplysical Restraint Assertaint As	ned no documented tive measures and ad. ned no documented ment to terminate the during the 2 hour removal riod. ere not updated to include nitted to the facility on 9/17/08 ding Altered Mental State; Hypertension; Anxiety Pain; Pneumonia, ty; and Other Mental s: on 9/23/08 at 0800, "Posey s) safety." hysical restraint sticker as les and procedures listed all Restraint Order Sticker is ian's order sheet" of an acceptable rational for ecifications of duration" ed in the policy (Titled: Procedures, Restraint, - R - 5 through 12) were not d. The forms included ssessment, Physical	A	164			
		Restraint Chart Checklist,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		290042	B. WING		09	/26/2008
	OVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE BVEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 164	Informed Consent Recare Plan Physical Recare Plan Physical Recare Plan Physical Research Tracking/Trending Loss. 3. The record contain less restrictive measured. 4. The record contain a reassessment to te done during the 2 horogenistic period at: 0800 (AM); 1400 (2 PM); 1600 (4 PM); and 2200 (10 PM); and 2200 (10 PM); and 2200 (10 PM); and 2200 (10 PM); and 2000 (8 PM) "pt a unsteady gait"; and B. 2000 (8 PM) "pt a unsteady gait". The "Patient Care Notas: 2100 (9 PM), "Patient Care Notas: 2100 (9 PM), "Patient With Posey versions. The care plans we use of restraints. Patient #29 was admitted with diagnoses included.	estraint Use, Interdisciplinary destraint, and Restraint og. led no documented evidence are and alternatives were led no documented evidence reminate the restraints was ar removal and repositioning 1000 (10 AM); 1200 (noon); PM); 1800 (6 PM); 2000 (8 M). Ion of the 9/24/08 "Patient led staff initialed off at eight 2 le were only 2 entries made in letter to get out of bed, letter to get out of bed, letter to get out of bed, letter is awake, alert with no les any pain or discomfort. Lest on for safety." The not updated to include the litted to the facility on 9/17/08	A 164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	26/2008
	ROVIDER OR SUPPLIER	BILITATION HOSPITAL	•	2170	FADDRESS, CITY, STATE, ZIP CODE EAST HARMON AVENUE VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 164	type: B (bilateral) so pulling out tubes 9/25/08; time 0900 type: wrist restraints (peripherally inserte for fall. 2. The "Restraints" Care Record" indica hour intervals (0200 0600 - 6 AM). Then 3. The forms specific Nursing Policies and original: 3/2006; NF in the patient's record Physical Restraint A Restraint Follow-Up Informed Consent F Care Plan Physical Tracking/Trending L 4. The record contaevidence less restrical ternatives were trice. 5. The record contaevidence that reass restraints was done and repositioning periods. On 9/25/08 at 4:3 plans in the patient's an unidentified emporare available for parenty of the pa	of (8:00AM); duration 24 hr; off wrist restraints; reason: of (9:00AM); duration 24 hr; off; reason: pulls out PICC discentral catheter) line, risk portion of the 9/24/08 "Patient atted staff initialed off at three 2 of 2 AM; 0400 - 4 AM; and discentral catheter and a unreadable entries. Official in the policy (Titled: discentral discen	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		290042	B. WING _		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	S	TREET ADDRESS, CITY, STATE, ZIP COI 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 164	daughter reported the came in to visit at 8 A the staff told her the restraints at approxin because the patient of The daughter indicate less restrictive alternative patient was put in Patient #30 was admitted with diagnoses included Pneumonitis; Hyperted Mental disorder; and Bronchitis. 1. Restraint Orders: - 9/19/08; time 1800 type: wrist restraints; (nasogastric feeding - 9/21/08; time 1800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 0800 type: wrist restraints; (nasogastric feeding - 9/25/08; time 08	was in wrist restraints. The ey were informed when they AM. The daughter reported patient went into the nately midnight and it was was pulling out his tubes. ed the staff did not express atives were attempted before nto restraints. Initted to the facility on 9/11/08 ding Food/Vomit ension; Dysphagia;Other Obstructive Chronic (6 PM); duration: 24 hour; reason: pulls out oxygen (6 PM); duration: 24 hour; reason: pulls out NGT tube). (6 PM); duration: 24 hour; reason: pulls out NGT tube). (8 am); duration: 24 hour; reason: pulls out NGT tube). (8 am); duration: 24 hour; reason: pulls out NGT tube). (9 am); duration: 24 hour; reason: pulls out NGT tube). (10 am); duration: 24 hour; reason: pulls out NGT tube). (11 am); duration: 24 hour; reason: pulls out NGT tube). (12 am); duration: 24 hour; reason: pulls out NGT tube).	A 16			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	l \ /	(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
	290042	B. WING		09	/26/2008	
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABIL	ITATION HOSPITAL	2170	r Address, City, State, Zip Code East Harmon Avenue VEGAS, NV 89119	•		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
bilateral restraints, all 3. The "Restraints" por Care Record" indicated of 2 hour intervals (080 AM). There were 2 wrown A. "Patient bilateral work every 2 hours or when the patient. Restraints pulse present, no rednead Patient given ice chips B. "Bilateral wrist rest (nasogastric) tube. Che 2 hours released at time. The "Patient Care Note A. 1200 (noon) "pat bed, Bilateral wrist rese wife monitors the patien B. 1400 (2 PM) "patien supervises bilateral wrown 4. The "Restraints" por Care Record" indicate hour intervals 0800 (8 (noon); 1400 (2 PM); 1 PM). There was 1 writerestraints." The "Patient Care Note the patient of t	es" portion recorded: checked for circulation in pulses present." ortion of the 9/21/08 "Patient d staff initialed off 24 hours 00 - 8 AM through 0600 - itten entries: rist restraints removed a family member supervises aremoved for circulation all less or edema noted. So, oral done frequently" and raints on patient pulled ng necked restraints q (every) nes for circulation." es" portion recorded: itent calm resting on the traints removed, patient ent." not calm resting in bed wife rist restraints off" ortion of the 9/23/08 "Patient d staff initialed off at six 2 AM); 1000 (10 AM); 1200 (1000 (4 PM); and 1800 - (6 tten entry: "Both wrist"); on bilateral soft wrist	A 164				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		290042	B. WIN	IG		09/20	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 164	original: 3/2006; NP in the patient's record Physical Restraint As Restraint Follow-Up, Informed Consent Re Care Plan Physical R Tracking/Trending Lo. 6. The record containe vidence less restrict alternatives were trie. The facility presented use of restraint. 1. The facility policy policy), documented Medicare Hospital Contained Patient Rights; JCAH Accreditation): 2004 - on page 1, item 3 - restrictive method that will be applied only a been attempted and signed the season of the communication skills measures must be done on page 2, item 4 - documented" - on page 2, item 9 - accordance with an immodification to the cate only in an exception, (POC) that was modicare procedures faile page 4, item 10 - "Items and the contained page 4, item 10 - "Items and the contained page 4, item 10 - "Items and the page 4, items and the page 4, items and the page 4, items and the page 4.	Procedures, Restraint, - R - 5 through 12) were not d. The forms included desessment, Physical Restraint Chart Checklist, destraint Use, Interdisciplinary destraint, and Restraint dg. Inded no documented dive measures and dd. If five different policies on the dittled Restraints (undated don page 4 was "References: conditions of Participation: O (Joint Commission Patient Care Standards." "The use of the least at meets the patient needs fer alternative methods have failed to meet patient needs A listed examples of dision activities, denvironment). Alternative documented" "alternatives must be "The restraint order will be in mediate written are plan, i.e., it will be used in response to a plan of care fied after the use of normal dd."	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABII	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 164	within the 24 hour time order if alternatives a is terminated early an evident." - page 4, item 11 - ". addresses restraint usongoing monitoring a be updated only after been tried and found are updated as soon restraint has been de necessary. The care frequency and monitorent on page 8, item 8 - "is discussed with the whenever possible ar requiring the need for behavioral condition rand the patient's under 2. The facility policy 309km, Restraint Prowith the most current approval signatures vor 1/8/07" documented to no page 2 item polic restrictive method that will be applied only af been attempted and for (see Attachment A - alternatives i.e. divers communication skills, measures must be documented and for the surface of the surfa	nt. Staff may release me limit, based on ginal order can be reapplied, ne frames of the original re ineffective, when restraint and the same behavior is POC (plan of care) se and documentation of and care. Care plans are to restraint alternatives have to be ineffective. Care plans as possible after the termined appropriate and plan will address the oring. The possible use of restraint patient and/or family and include behaviors restraint and what resulting in restraint removal erstanding of the same." titled "Nursing Services, cedure, 4 pages dated 7/93 revision dated 12/06, were dated 1/2/07 and the following: by 3 - "The use of the least at meets the patient needs at meets the patient needs at listed examples of sion activities, environment). Alternative bocumented." by 4 - "Initial assessment,	A	164			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		290042	B. WIN	G		09/2	26/2008	
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	•	2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE DVEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 164	must assess the pat need" - on page 3, item 8 - is discussed with the whenever possible a requiring the need for behavioral condition and the patient's uncompage 3, item 11 restraint use and do monitoring and care updated only after rebeen tried and found are updated as soor restraint has been donecessary." 3. The facility policy 309gf, Restraint Prowith the most current approval signatures - The items mirrored "Nursing Services, 3 pages dated 7/93 with dated 12/06, approved 1/2/07 and 1/8/07". 4. The facility policy Procedures, Restraint 5 through 12" document on page R-5, item be used unless the form (IDT) has come evaluation to identify environmental factor restrictive alternative and signatures.	- "an RN (Registered Nurse) ient daily to determine the "the possible use of restraint e patient and/or family and include behaviors or restraint and what resulting in restraint removal derstanding of the same." - "Plan of Care addresses cumentation of ongoing . Care plans are to be estraint alternatives have It to be ineffective. Care plans as possible after the etermined appropriate and titled "Nursing Services, cedure, 5 pages dated 7/93 t revision dated 12/03, no were on the procedure." d the later approved version 09km, Restraint Procedure, 4 th the most current revision al signatures were dated titled "Nursing Policies and nt, original: 3/2006; NP - R -	A	164				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	290042	B. WIN	G		09/2	6/2008
	LITATION HOSPITAL	•	2170	0 EAST HARMON AVENUE		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	I		(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
behavior threatens h - There was 1 set of follows: - on page R-5, item p	is own health or safety" procedures identified as procedures 1 - "with a	A	164			
restraint order and/or the nurse completes establishes a plan, or updates the care plan plan." - on page R-5, item promeets as soon as possessment, and confiniter ventions have be implementedmain functioning with the lessing of the compage R-6, item apprior to consideration documented in the perior to consideration	r as condition necessitates, a restraint assessment, btains an order, consent and in prior to implementing the procedures 2 - "The IDT is sible to review the insider if all alternatives and in the highest level of it is east restrictive measures." I - "All alternatives attempted in of using restrain are in atteint's medical record." I - "Documentation of its is maintained in the insider and care planning." I - "It is further is indicate the need for engages in a systematic and in ards reducing restraints." I the sample forms to be estraint Assessment; ecklist; Informed Consent; Restraint; and Tracking and its its indicate the restraints."					
Know, Untying the M	ysteries of Restraints";					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page behavior threatens h - There was 1 set of follows: - on page R-5, item prestraint order and/or the nurse completes establishes a plan, o updates the care plan plan." - on page R-5, item prestraint order and/or interventions have be implementedmain functioning with the le- on page R-6, item 4 prior to consideration documented in the proper or page R-6, item 6 restraint effectivenes medical record." - on page R-6, item 9 warrant the use of re comprehensive asse - on page R-6, item 1 expectedcare plans restraints the facility gradual process towa - on page R-7-12 are used for: Physical R Follow-up; Chart Che Care Plan - Physical Trending Log. 5. The facility policy to Know, Untying the M	CONTIDENTIFICATION NUMBER: 290042 ROVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 behavior threatens his own health or safety" - There was 1 set of procedures identified as follows: - on page R-5, item procedures 1 - "with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implementedmaintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restrain are documented in the patient's medical record." - on page R-6, item 9 - "Documentation of restraint effectiveness is maintained in the medical record." - on page R-6, item 9 - "Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expectedcare plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - on page R-7-12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and	A BUIL 290042 DOVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 behavior threatens his own health or safety" - There was 1 set of procedures identified as follows: - on page R-5, item procedures 1 - "with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implementedmaintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restrain are documented in the patient's medical record." - on page R-6, item 8 - "Documentation of restraint effectiveness is maintained in the medical record." - on page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expectedcare plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - on page R-7-12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. The facility policy titled "What You Need to Know, Untying the Mysteries of Restraints";	A BUILDING 290042 STREE MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 behavior threatens his own health or safety" - There was 1 set of procedures identified as follows: - on page R-5, item procedures 1 - "with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implementedmaintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restrain are documented in the patient's medical record." - on page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 9 - "Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expectedcare plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - on page R-7-12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. The facility policy titled "What You Need to Know, Untying the Mysteries of Restraints";	CONTRECTION DENTIFICATION NUMBER: 290042 290042 3 200042 3 200042 3 200042 3 200042 3 200042 3 200042 3 3 200042 3 200042 3 200042 3 200042 3 3	COMPLET 29042 STREET ADDRESS, CITY, STATE, JP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NY 39119 SUMMARY STATEMENT OF DEPOILDINGS (EACH DEPOILDINGS) (EACH DEPOILDING WISH SEE PRECEDED BY YILL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 behavior threatens his own health or safety" - There was 1 set of procedures 1 - "with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implementedmaintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restrain are documented in the patient's medical record." - on page R-6, item 9 - "Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expectedcare plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restrains." - on page R-7.12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint, and Tracking and Trending Log. 5. The facility policy titled "What You Need to Know, Untying the Mysteries of Restraints";

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		ng	/26/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		120/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 164	pages 4-5. - The items mirrored "Nursing Policies and original: 3/2006; NP 6. The instructions of the "Daily Patient Cathe timed box the pacirculation/skin condipatient need for hydrogen toileting. Indicate if not patient need for hydrogen toileting. Indicate if not need for hydrogen to policy in the not policy review and procedures on any policy review) and in was what corporate of the Staff Developer training session 9/9/10 training the staff. 9. Interviews with Charles from each of the not necessarily training interviews revealed: - The staff had an idnot necessarily training the fadoing training on the competencies were decomposed in the normal policy in the staff.	the later approved version deprocedures, Restraint, - R - 5 through 12". If the "Restraints" portion of the Record" read: "Initial in tient was checked for the ition under the restraint and the restraint and the restraint on/off." afternoon, the Acting DON reported the policies olicies utilized by the facility. morning, the Staff of another Nursing Policies Restraints (refer to item #4 in dicated this restraint policy wanted the facility to utilize. The reported she just began (first 108 and the second 9/17/08) the arge Nurses (RN) and Floor the 6 units were conducted the facility, and LPN shares) could not recall if she incility, other staff remembered computer, one staff reported	A 164			

	OF DEFICIENCIES CORRECTION			(X3) DATE SUR COMPLETE			
		290042	B. WIN	IG_	 	09/20	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 164	- The staff were unsures and were unaware the staff were unsurestraints and what to were removed. Some were kept in the supprestraints were kept in the suppresented restraints at the unit. One RN staff were unsufamily, some staff staff amily unless it was in the wrist restraints are staff were averestraint use. Most of would document on the one mentioned update one mentioned update. One RN mentioned alternative measures 482.13(e)(3) PATIEN OR SECLUSION The type or technique used must be the lea will be effective to profrom harm. This STANDARD is Based on interview, or review the facility failer restraint used must be the learness and the staff was an	re of what the facility policy re of where it was located. re of where to obtain to do with them after they e staff thought restraints by room, others said in the laundry, another hall that were kept on a cart on ted she would throw away and Posey vests after use. The if they were to inform the ted they would call the hight. Ware of where to document if the RNs reported they he daily nursing notes. No hing the Care Plan. Least restrictive and prior to restraint application. T RIGHTS: RESTRAINT The of restraint or seclusion is the restrictive intervention that other the patient or others Thought the patient or others The of the patient or others The of the patient or others in the patient or others The of the patient or others in the patient or others The of the patient or others in the patient or other in the pa		164			
	restrictive intervention #28, #29, #30).	n for 4 of 36 patients (#1,					

			(X3) DATE SUF COMPLETI				
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 165	Continued From page	e 42	A	165			
	12/28/07 and dischardiagnoses including In Debility; and Other Modern In The patient had physis 1/16/08, for a posey patient was trying to assistance, a history awareness. A review of Patient # was no documented measures and alternated patient was placed in 2. Patient #28 was as 9/17/08 with diagnos State; Depressive Diagnoses State; Depressive Diagnoses of the Phypertension; Debilit Condition. The patient had a physis for a posey vest for some tried.	Pneumonia; Hypertension; lental Condition sican orders from 12/29/07 - vest retraint due to the get out of bed without of falling, and no safety 1's record revealed there evidence less restrictive atives were tried before the restraints. dmitted to the facility on es including Altered Mental sorder; Hypertension; Chronic Pain; Pneumonia, cy; and Other Mental ysician order dated 9/23/08, safety. d no documented evidence ures and alternatives were					
	9/17/08 with diagnos Cardiomyopathy; Edd Hypoxemia.	dmitted to the facility on es including Pleural Effusion; ema; Atrial Fibrillation; and					
	A review of the recor	d revealed the patient had a					

B. WING		
290042 B. WING 09	09/26/2008	
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 165 Continued From page 43 physician order for bilateral soft wrist restraints on 9/25/08 due to the patient was pulling out tubes. The record documented the patient was pulling out the peripherally inserted central catheter (PICC) and was a risk for falls. The record contained no documented evidence less restrictive measures and alternatives were tried. The record contained no documented evidence a reassessment to terminate the necessity or the least restrictive restraint was completed during the removal and repositioning period. 4. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. A review of the records revealed the patient had a physician order from 9/19/08 - 9/25/08 for wrist retraints due to pulling out the nasal oxygen tubing and the nasogastric feeding tube. The record contained no documented evidence less restrictive measures and alternatives were tried. The facility presented five different policies on the use of restraint. 1. The facility policy titled "Restraints (undated) documented the following:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 165	(see Attachment A - alternatives i.e. divers communication skills, measures must be do - on page 2, item 4 - documented" - on page 4, item 10 reassessment may premination of restrain restraint before the time assessment. The oriwithin the 24 hour time order if alternatives a is terminated early are evident." - on page 4, item 11 restraint use and documented and found are updated only after respect tried and found are updated as soon restraint has been denecessary. The care frequency and monitor in the most current approval signatures with the most current approval signatures with the most current approval signatures with the applied only are been attempted and it (see Attachment A - alternatives i.e. divers communication skills measures must be do	A listed examples of sion activities, environment). Alternative ocumented. "alternatives must be "Monitoring and ermit the reduction or early not. Staff may release me limit, based on ginal order can be reapplied, not from the frequency of the original respective, when restraint not the same behavior is "Plan of Care addresses umentation of ongoing Care plans are to be estraint alternatives have to be ineffective. Care plans as possible after the termined appropriate and plan will address the oring." titled "Nursing Services, cedure, 4 pages dated 7/93 revision dated 12/06, were dated 1/2/07 and the following: by 3 - "The use of the least at meets the patient needs feer alternative methods have failed to meet patient needs A listed examples of sion activities, environment). Alternative	A 165			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 165	must assess the patineed" - on page 3, item 11 restraint use and door monitoring and care. updated only after rebeen tried and found are updated as soon restraint has been donecessary." 3. The facility policy 309gf, Restraint Produith the most current approval signatures documented the samabove. 4. The facility policy Procedures, Restraint 5 through 12" documented the samabove. 4. The facility policy Procedures, Restraint 5 through 12" documented the samabove. 4. The facility policy Procedures, Restraint 5 through 12" documented the samabove. 5 through 12" documented the samabove. - on page R-5, item prestrictive alternative Emergency is defined behavior threatens here the samabove. - on page R-5, item prestraint order and/order and/ord	"an RN (registered nurse) ent daily to determine the - "Plan of Care addresses cumentation of ongoing Care plans are to be straint alternatives have to be ineffective. Care plans as possible after the etermined appropriate and titled "Nursing Services, cedure, 5 pages dated 7/93 a revision dated 12/03, no were on the procedure" the information as listed titled "Nursing Policies and at, original: 3/2006; NP - R -	A	165			

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED					
		290042	B. WING	S	09/	/26/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE . CROSS-REFERENCED TO DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
A 165	updates the care plan plan". -on page R-5, item properties as soon as possible assessment, and consister and consister and consister and approaches in the approaches must increlease, and repositing and approaches in the approaches must increlease, and repositing and approaches in the approaches must increlease, and repositing and approaches in the approaches must increlease, and repositing and approaches in the approaches in th	btains an order, consent and n prior to implementing the rocedures 2 - "The IDT possible to review the ensider if all alternatives and een selected and ain the highest level of east restrictive measures." 4 - "All alternatives attempted in of using restraint are attent's medical record." 7 - "Enter the problem, goal the patient's care plan. The clude frequent observation, on" 8 - "Documentation of its is maintained in the estraints are reflected in the essment and care planning."	A 1	165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WING	i		09/26/2008		
	OVIDER OR SUPPLIER	ILITATION HOSPITAL		2170 I	ADDRESS, CITY, STATE, ZIP CODE EAST HARMON AVENUE VEGAS, NV 89119		20/2000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 165	Continued From pag	je 47	A 1	65				
	and Procedures on policy review) and ir was what corporate The Staff Developer training session 9/9/training the staff. 8. Interviews with Cl Nurses from each of on 9/25/08 beginning interviews revealed: - the staff had an ide not necessarily train (Licensed Practical was trained by the fadoing training on the competencies were	d another Nursing Policies Restraints (refer to item #4 in idicated this restraint policy wanted the facility to utilize. reported she just began (first 08 and the second 9/17/08) marge Nurses (RN) and Floor if the 6 units were interviewed g at 10:30 AM. The ea of restraint use, but were ed at the facility, an LPN Nurse) could not recall if she acility, other staff remembered e computer, one staff reported completed yearly. A RN of trained however she could						
		re of what the facility policy are of where it was kept.						
	restraints and what is were removed. Son were kept in the sup restraints were kept presented restraints the unit. One RN st the wrist restraints a	re of where to obtain to do with them after they he staff thought restraints ply room, others said in the laundry, another hall that were kept on a cart on ated she would throw away nd Posey vests after use.						
		of the RNs reported they the daily nursing notes. No						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG _		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 165	Continued From page one mentioned update		A	165			
A 166		least restrictive and prior to restraint application. ENT RIGHTS: RESTRAINT	A	166			
		or seclusion must be a written modification to the					
	Based on interview, or review, the facility fail restraint was in accor	atient's plan of care for 4 of					
	Findings Include:						
	12/28/07 and dischar	Pneumonia; Hypertension;					
	physician orders date Posey vest restraint of	d indicated the patient had ed 12/29/07 - 1/16/08 for a due to trying to get out of bed istory of falls, and no safety					
	The care plans were use of restraints.	not updated to include the					
	9/17/08 with diagnose State; Depressive Dis	dmitted to the facility on es including Altered Mental sorder; Hypertension; Chronic Pain; Pneumonia, y; and Other Mental					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	, 30.2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	I .	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 166	physician order dated Vest for pts' (patient's The care plans were use of restraints. 3. Patient #29 was ac 9/17/08 with diagnost Cardiomyopathy; Ede Hypoxemia. A review of the recomphysician orders date wrist restrains due to tubes (peripherally in On 9/25/08 at 4:30 P in the patient's record unidentified employed care available for pat 4. Patient #30 was ac 9/11/08 with diagnost Pneumonitis; Hyperte Mental disorder; and Bronchitis. A review of the recomphysician orders date restraints due to pulli and nasogastric feed	d indicated the patient had a d 9/23/08 at 0800 for "Posey s) safety." not updated to include the dmitted to the facility on es including Pleural Effusion; ema; Atrial Fibrillation; and dindicated the patient had ed 9/25/08 for bilateral soft the patient was pulling out serted central catheter). M, there were no care plans die confirmed there was no ient #29. Idmitted to the facility on es including Food/Vomit ension; Dysphagia; Other Obstructive Chronic di indicated the patient had ed 9/19/08 - 9/25/08 for wristing out oxygen nasal tubing	A	166			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	217	ET ADDRESS, CITY, STATE, ZIP CODE 0 EAST HARMON AVENUE S VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 166	The facility presented use of restraint. 1. The facility policy 6 pages, on page 4 v. Hospital Conditions of Rights; JCAHO (Join 2004 Patient Care St. on page 3, item 6b will reflect increased intervals to a hour intindicated" - on page 4, item 11 restraint use and do monitoring and care. updated only after rebeen tried and found are updated as soon restraint has been denecessary. The care frequency and monitoring the need fo behavioral condition and the patient's und 2. The facility policy 309km, Restraint Prowith the most current approval signatures v. 1/8/07" documented	titled "Restraints (undated), vas "References: Medicare of Participation: Patient to Commission Accreditation): andards." - "The patient's care plan monitoring from 2 hour ervals, as medically - "Plan of Care addresses umentation of ongoing Care plans are to be straint alternatives have to be ineffective. Care plans as possible after the termined appropriate and plan will address the being. "the possible use of restraint patient and/or family and include behaviors or restraint and what resulting in restraint removal erstanding of the same." titled "Nursing Services, cedure, 4 pages dated 7/93 revision dated 12/06, were dated 1/2/07 and the following: "the possible use of restraint patient and/or family and include behaviors "the possible use of restraint patient and/or family and include behaviors	A 166			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL		21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 166	behavioral condition and the patient's und- on page 3, item 11- restraint use and doc monitoring and care. updated only after restraint has been denecessary." 3. The facility policy 309gf, Restraint Proc with the most current approval signatures w - The items mirrored (as listed above). 4. The facility policy t Procedures, Restraint 5 through 12" docum- on page R-5, item p restraint order and/or the nurse completes establishes a plan, of updates the care plar plan" on page R-5, item p (interdisciplinary tean possible to review the if all alternatives and selected and impleme level of functioning w measures." - on page R-6, item 7 and approaches in th	resulting in restraint removal erstanding of the same." "Plan of Care addresses umentation of ongoing Care plans are to be straint alternatives have to be ineffective. Care plans as possible after the termined appropriate and titled "Nursing Services, edure, 5 pages dated 7/93 revision dated 12/03, no were on the procedure." Ithe later approved version Ittled "Nursing Policies and t, original: 3/2006; NP - R - ented the following: rocedures 1 - "with a as condition necessitates, a restraint assessment, of ains an order, consent and in prior to implementing the procedures 2 - "The IDT in) meets as soon as a assessment, and consider interventions have been entedmaintain the highest ith the least restrictive - "Enter the problem, goal the patient's care plan. The ude frequent observation,	A	166			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	'	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	30.2	0. 200 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 166	- on page R-6, item 9 warrant the use of recomprehensive asset on page R-6, item 1 expectedcare plans restraints the facility gradual process towarent proce	In a "Medical symptoms that straints are reflected in the sement and care planning." In a "It is further is indicate the need for engages in a systematic and ards reducing restraints." In a the sample forms to be estraint Assessment; Incklist; Informed Consent; Restraint; and Tracking and itled: "What You Need to estraint; and Procedures, (2006, Revision 3/2008; Ithe later approved version In a the sample forms to be estraint and the policies in the facility. In a the sample forms to be estraint and the policies and Procedures, (2006, Revision 3/2008; Ithe later approved version In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; Ithe later approved version In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; Ithe later approved version In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; Ithe later approved version In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; In a the sample forms to be estraints and procedures, (2006, Revision 3/2008; In a the sample forms to be estraints. The sample forms to be estraints and procedures, (2006, Revision 3/2008; In a the sample forms to be estraints. The sample forms to be e	A	166			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G	 	09/20	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 166	not necessarily trained (Licensed Practical Nas trained by the far doing training on the competencies were of Registered Nurse rephowever she could go the staff were unaway and were unaway and were unaway to the staff were kept in the supprestraints were kept in the suppresented restraints at the unit. One RN staff the unit. One RN staff the unit with the wrist restraints are the staff were unaur family, some staff staff amily unless it was restraint use. Most of would document on the staff were away to staff	a of restraint use, but were and at the facility, an LPN lurse) could not recall if she cility, other staff remembered computer, one staff reported completed yearly. A corted she was not trained to to her supervisor. The of what the facility policy are of where it was kept. The of where to obtain to do with them after they be staff thought restraints only room, others said in the laundry, another hall that were kept on a cart on the she would throw away and Posey vests after use. The if they were to inform the ted they would call the hight. The reare of where to document of the RNs reported they he daily nursing notes.	A	166			
A 169			А	169			
		restraint or seclusion must standing order or on an as					
	This STANDARD is	not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 169	review, the facility fai was obtained for each patients (#1, #28). Findings Include: 1. Patient #1 was add 12/28/07 and dischard diagnoses including Inclu	document review and record led to ensure a written order th use of restraint for 2 of 36 mitted to the facility on reged on 1/16/08 with Pneumonia; Hypertension; lental Condition 5AM; duration 24 hour; type o get out of bed/hx (history) 0 (7:00AM); duration 24 hr; ason: climbs out of bed no e order was used to reapply of AM and 12:00 PM notes repositioned", the 2:00 PM ated "off during family visit", ated "released and obtained after the restraint er reapplied within the same ew order was required, the porder constitutes a PRN (as 44 hour period. dmitted to the facility on es including Altered Mental sorder; Hypertension; Chronic Pain; Pneumonia,	A 169			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
A 169	Continued From page	e 55	A	169				
	AM), "Posey Vest for	on 9/23/08 at 0800 (8:00 pts' (patient's) safety." er did not contain the restraint use.						
	Care Record" indicate hour intervals. There this section: A. "Pt (patient) attem unsteady gait", and B. 2000 (8 PM) "pt a unsteady gait".	attempts to get out of bed,						
	recorded as: 2100 (9 alert with no distress	otes" portion (9/24/08) were 9 PM), "Patient is awake, noted. Denies any pain or with Posey vest on for						
	The facility presented use of restraint.	d five different policies on the						
	conflict with the "can needed)". Discontinu	s and procedures were in not use as PRN (as uation of a restraint and then e same order constitutes a						
	pages, on page 4 wa Hospital Conditions of Rights; JCAHO (Join: 2004 Patient Care St on page 4, item 10	- "Monitoring and ermit the reduction or early						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 169	within the 24 hour time order if alternatives as is terminated early are evident." 4. The facility policy the 309km, Restraint Prowith the most current approval signatures of 1/8/07" documented in	me limit, based on ginal order can be reapplied, he frames of the original re ineffective, when restraint and the same behavior is sittled "Nursing Services, ocedure, 4 pages dated 7/93 revision dated 12/06, were dated 1/2/07 and the following: - "Monitoring and ermit the reduction or early not. Staff may release me limit, based on ginal order can be reapplied, he frames of the original re ineffective, when restraint and the same behavior is sittled "Nursing Services, bedure, 5 pages dated 7/93 revision dated 12/03, no were on the procedure". Ithe later approved version afternoon, the Acting DON reported the policies licies utilized by the facility. FIENT RIGHTS:	A 169			
	[there must be documedical record of]	nentation in the patient's				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
A 186	Continued From page	e 57	A	186				
	attempted (as application of this STANDARD is	not met as evidenced by:						
	review, the facility fai	record review, and document led to ensure alternatives of entions were attempted for 4 (8, #29, #30).						
	Findings Include:							
	12/28/07 and dischar	Pneumonia; Hypertension;						
	physician orders date Posey vest restraint of	d indicated the patient had ed 12/29/07 - 1/16/08 for a due to trying to get out of bed istory of falls, and no safety						
	Policies and Procedu	n the policy (Titled: Nursing ires, Restraint, original: rough 12) were not in the						
		I no documented evidence ures and alternatives were						
	9/17/08 with diagnos State; Depressive Diagnos	dmitted to the facility on es including Altered Mental sorder; Hypertension; Chronic Pain; Pneumonia, y; and Other Mental						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL		2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 186	written on 9/23/08 at for pts' (patient's) saf for pts' (patient's) saf The record contained less restrictive measitried. 3. Patient #29 was at 9/17/08 with diagnos Cardiomyopathy; Edd Hypoxemia A review of the record dated 9/25/08 at 080 (9:00AM) for bilatera pulling out tubes (per catheter) and a risk for The record contained less restrictive measitried. The record contained that a reassessment was done during the repositioning period. On 9/25/08 at 10 AM #29's daughter and wheen notified Patient The daughter reported the staff told restraints at approximate because the patient of the daughter indication.	d indicated an order was 0800 (8:00AM), "Posey Vest fety." d no documented evidence ures and alternatives were dmitted to the facility on es including Pleural Effusion; ema; Atrial Fibrillation; and d indicated physician orders 0 (8:00AM) and 0900 I soft wrist restraints due to ripherally inserted central or falls. d no documented evidence ures and alternatives were d no documented evidence to terminate the restraints	A	186			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	217	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST HARMON AVENUE S VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 186	4. Patient #30 was an 9/11/08 with diagnos Pneumonitis; Hyperto Mental disorder; and Bronchitis. A review of the recordated 9/19/08 - 9/25/the patient pulling our nasogastric feeding to The "Restraints" port Care Record" indicated for 2 hour intervals (O. AM). The written end A. "Patient bilateral every 2 hours and wisupervises the patien redness noted, all purpresent." B. six entries were a circulation." The "Patient Care Noted A. 1430 (2:30 PM)" bilateral restraints, and The "Restraints" port Care Record" indicated for 2 hour intervals (O. AM). There were 2 will bilateral wrist restraints removed for present, no redness given ice chips, oral for B. "Bilateral wrist restraints restraints."	dmitted to the facility on es including Food/Vomit ension; Dysphagia;Other Obstructive Chronic d indicated physician orders 08 for wrist restraints due to toxygen nasal tubing and ube. ion of the 9/19/08 "Patient ed staff initialed off 24 hours 800 - AM through 0600 - cries included: wrist restraints released then family member to for circulation, hydration, alses of upper extremities Ill recorded as "Checked otes" portion recorded: checked for circulation in the 9/21/08 "Patient ed staff initialed off 24 hours 800 - 8 AM through 0600 - critten entries: A. "Patient the staff initialed off 24 hours 800 - 8 AM through 0600 - critten entries: A. "Patient the or circulation all pulse or edema noted. Patient done frequently" and straints on patient pulled ng entre q (every) 2 hours	A 186			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL		217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE IS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 186	Continued From pag	e 60	A	186			
	A. 1200 (noon) "p bed, Bilateral wrist re wife monitors the par B. 1400 (2 PM) "pat supervises bilateral with the record contained less restrictive meastried. The record contained less restrictive meastried. The facility presented use of restraint. 1. The facility policy pages, on page 4 was Hospital Conditions of Rights; JCAHO (Join 2004 Patient Care Son page 1, item 3 restrictive method the will be applied only a been attempted and (see Attachment Aoalternatives i.e. diversed communication skills measures must be don page 2, item 4 documented" on page 3, item communication skills measures must be don page 3, item communication skills measures must be don page 3, item compage 3, ite	ient calm resting in bed wife wrist restraints off" If no documented evidence ures and alternatives were alternatives were alternatives were different policies on the stitled "Restraints (undated), 6 as "References: Medicare of Participation: Patient at Commission Accreditation): tandards." "The use of the least at meets the patient needs at meets the patient needs after alternative methods have failed to meet patient needs A listed examples of sion activities, environment). Alternative ocumented. "alternatives must be "Reason for the restraint, acceptable." titled "Nursing Services, ocedure, 4 pages dated 7/93 at revision dated 12/06, were dated 1/2/07 and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 186	will be applied only a been attempted and (see Attachment A - alternatives i.e. diver communication skills measures must be de on page 2 item polic continuous, and alter documented" - on page 2 item 5a - must assess the patineed" 3. The facility policy to 309gf, Restraint Produith the most current approval signatures and commented: - The items mirrored (as listed above). 4. There was 1 set of follows: - on page R-5, item (interdisciplinary tear possible to review the if all alternatives and selected and implem highest level of funct restrictive measures on page R-6, item 4 prior to consideration documented in the page on page R-6, item 1 expectedcare plans	at meets the patient needs fter alternative methods have failed to meet patient needs A listed examples of sion activities, , environment). Alternative ocumented." by 4 - "Initial assessment, matives must be "an RN (registered nurse) ent daily to determine the ditled "Nursing Services, bedure, 5 pages dated 7/93 be revision dated 12/03, no were on the procedure" the later approved version f procedures identified as procedures 2 - "The IDT m) meets as soon as the assessment, and consider interventions have been the entedmaintain the tioning with the least the "All alternatives attempted to of using restraint are attent's medical record."	A	186			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN			00/2	C/2008
	OVIDER OR SUPPLIER			21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	1 09/2	6/2008
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF COI PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
A 186	- on page R-7-12 are used for: Physical Re Follow-up; Chart Che Care Plan - Physical Trending Log. 5. On 9/25/08 in the (Director of Nursing) provided were the po 482.13(f) PATIENT R	trds reducing restraints." the sample forms to be estraint Assessment; cklist; Informed Consent; Restraint; and Tracking and afternoon, the Acting DON		186			
	implementation of resistaff. This STANDARD is a Based on interview the	n: Staff Training patient has the right to safe straint or seclusion by trained not met as evidenced by: se facility failed to ensure the implementation of restraint					
	by ensuring staff were implementation of res	e trained on the safe					
	presented a Nursing Restraints and indica (Titled: "What You Ne Mysteries of Restrain Policies and Procedu 3/2006, Revision 3/20 wanted the facility to reported she just beg 9/9/08 and the second	morning, the Staff Developer Policies and Procedures on ted this restraint policy eed to Know, Untying the ts"; Section III Nursing res, Restraint, original: 008) was what corporate utilize. The Staff Developer an (first training session d 9/17/08) training the staff.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/26/200	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 194	Continued From page	e 63	A 194			
	each of the 6 units w beginning at 10:30 A - the staff had an idea not necessarily trained (Licensed Practical N was trained by the fa doing training on the competencies were of Registered Nurse (Ri trained however she - the staff were unsur	N) reported she was not could go to her supervisor. The of what the facility policy are of where it was kept.				
	restraints and what to were removed. Som were kept in the supprestraints were kept i presented restraints the unit. One RN stathe wrist restraints are the staff were unsuffamily, some staff state family unless it was re-	o do with them after they e staff thought restraints oly room, others said in the laundry, another hall that were kept on a cart on ted she would throw away and Posey vests after use. The if they were to inform the sted they would call the				
A 214	would document on to one mentioned update - One RN mentioned alternative measures	he daily nursing notes. No ting the Care Plan.	A 214			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 214	Continued From pag	e 64	А	214			
		quirements: Hospitals must ated with the use of seclusion					
	(1) The hospital mus information to CMS:	t report the following					
	Each death that occurestraint or seclusion	urs while a patient is in					
		urs within 24 hours after the noved from restraint or					
	within 1 week after re is reasonable to assu- placement in seclusion indirectly to a patient assume" in this conte to, deaths related to prolonged periods of	o the hospital that occurs estraint or seclusion where it ume that use of restraint or on contributed directly or 's death. "Reasonable to ext includes, but is not limited restrictions of movement for time, or death related to restriction of breathing or					
	be reported to CMS the close of business	enced in this paragraph must by telephone no later than is the next business day of the patient's death.					
		nent in the patient's medical time the death was reported					
	Based on interview a failed to ensure police	not met as evidenced by: and policy review, the facility ies and procedures were in quirements of reporting					

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG_		09/20	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 214	Incident Reporting, o LP I - 32". - The policy did not in required information and Medicare Service b. "Subject: Accider Patient/Resident, originary. - The policy did not in required information and Medicare Service - Item #11 on page 2 JCAHO reporting required Events" (JCAHO) produced that definition in c. "Subject: Sentine Facilities, 2006, LP I - The entire restraint	ave JCAHO (Joint tation. 3 policies: Unusual and Adverse riginal 3/2006 (no updates), aclude reporting any of the to CMS (Center for Medicaid es) in the required timelines. at/Incident Reporting - ginal 3/2006 (no updates), LP aclude reporting any of the to CMS (Center for Medicaid es) in the required timelines. stated "To determine uirements refer to "Sentinel ocedures, for incidents fall in the policy. I Event for Joint Accredited	A	214			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/26/	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 214 A 263	of Nursing made no c	e 66 norning, the Acting Director omment regarding the rting to Joint commission.		214 263			
		ongoing, hospital-wide, sessment and performance					
	the program reflects thospital's organization hospital departments those services furnish arrangement); and for	n and services; involves all and services (including ned under contract or cuses on indicators related ttcomes and the prevention					
	evidence of its QAPI This CONDITION is Based on record revie hospital administrator	intain and demonstrate program for review by CMS. not met as evidenced by: ew and interviews with the the facility failed to meet					
	Assurance Performar The facility did not de maintain an effective, driven quality assessi improvement progran (radiology, laboratory	cipation (COP) for Quality nee Improvement (QAPI). velop, implement and ongoing, hospital wide data ment and performance of for its contracted services, housekeeping, oxygen, control and blood gas labs).					
	performance improve	s quality assessment and ment program did not reveal es were included in the					

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP LDING	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL CX4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 263 Continued From page 67 quality assurance performance improvement program. On 9/26/08 at 1:30 PM, the Hospital Administrator reported the hospital did not include contracted services in the QAPI program. The Administrator reviewed quality assurance pinformation provided by the contractors yearly but did not have a record of the information available in the facility.			290042	B. WIN	IG		09/2	6/2008
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 263 Continued From page 67 quality assurance performance improvement program. On 9/26/08 at 1:30 PM, the Hospital Administrator reported the hospital did not include contracted services in the QAPI program. The Administrator stated he met with the contracted services representatives quarterly. The Administrator reviewed quality assurance information provided by the contractors yearly but did not have a record of the information available in the facility.			ILITATION HOSPITAL	•	2.	170 EAST HARMON AVENUE		
quality assurance performance improvement program. On 9/26/08 at 1:30 PM, the Hospital Administrator reported the hospital did not include contracted services in the QAPI program. The Administrator stated he met with the contracted services representatives quarterly. The Administrator reviewed quality assurance information provided by the contractors yearly but did not have a record of the information available in the facility.	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE
SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Director of Nursing failed to determine the number of registered nursing personnel necessary to provide nursing care to all areas of the hospital. Findings Include: 1. On 09/23/08 through 09/26/08 during the day shift, Licensed Practical Nurses (LPNs) were assigned and observed functioning as charge or lead nurses on the 400, 500 and 600 units of the facility. There were no Registered Nurses (RN) physically present and on duty at all times on the		quality assurance per program. On 9/26/08 at 1:30 Preported the hospital services in the QAPI stated he met with the representatives quarreviewed quality assiby the contractors yetercord of the informat 482.23(a) ORGANIZ SERVICES The hospital must hawith a plan of adminited delineation of responsible for the orincluding determining nursing personnel armursing care for all at This STANDARD is Based on observation review, the Director of the number of registencessary to provide the hospital. Findings Include: 1. On 09/23/08 through the hospital of the process of the decision of the provided the hospital. Findings Include: 1. On 09/23/08 through the hospital of the process of the decision of the process of the decision of the decision. There were the process of the process of the decision of the process of the decision. There were the process of the process of the decision of the process of the decision. There were the process of the process of the decision of the process of the decision.	offormance improvement off, the Hospital Administrator did not include contracted program. The Administrator are contracted services terly. The Administrator are contracted services at the Administrator are contracted services at the Administrator are contracted services at the Administrator are contracted service at the Facility. ATION OF NURSING of a well-organized service are always and assibilities for patient care. The Administrator are are always and numbers of and staff necessary to provide areas of the hospital. onot met as evidenced by: on, interview and document of Nursing failed to determine are nursing personnel and areas of the service and services are to all areas of the service and services are to all areas of the services and services are to all areas of the services and services are to all areas of the services (LPNs) were serviced functioning as charge or the Registered Nurses (RN)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/26/20	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	·	STREET ADDRESS, CITY, STATE, ZIP C 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 386	day shift. The LPNs opatient assignments without supervision for physically present or 2. On 09/24/08 at 1:2 Nursing (DON) report assigned and utilized the 300, 400, 500 and the day and night shift utilized as charge nur 1/2 years. The 100 at an RN as the charge of the patients on the The Acting DON report included making pating directing patient care and an RN were called 600 units to perform scope of practice of the (peripherally inserted and IV (intravenous) administration. The Acting DON report (peripherally inserted and IV (intravenous) administration. The Acting DON report Registered Nurses were usually through 600 units of 3. On 09/25/08 at 10 acknowledged being charge nurse for the #1 reported it was here	its of the facility during the were observed making and directing patient care rom a Registered Nurse in the units. 20 PM, the Acting Director of ted the LPNs were frequently as lead or charge nurses on the door on the LPNs had been reses for at least the past 2 and 200 units were assigned nurse due to the high acuity use units. Ported the lead LPNs duties and an on the units. Supervisors and to the 300, 400, 500 and nursing functions outside the he lead LPNs, such as PICC and central catheter) line flushes push medication Ported she was not aware are required to be physically of the facility to supervise mmediate bedside care of DON confirmed Registered not staffed on the 400 the facility.	A	386			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	LITATION HOSPITAL	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 386	LPN # 24 reported the not based on acuity of were based on the niside and "B" side of the assigned the patients and an LPN was asside of the unit. CNA and "B" side of the unit of the unit to perform care. LPN # 24 was asked patient coded on her RNs from the 100 or the emergency and racknowledged she heart on the unit and refunction. 4. On 09/25/08 at 10 acknowledged being charge nurse for the #25 reported her respatient assignments, transcribing physicial patient assignments diagnosis but on nunside or "B" side of the were assigned to the unit. LPN #25 confinor present on the 600 patient care or to masupervisor or RN had perform nursing functions.	ssigned to work on the unit. The patient assignments were or diagnosis. Assignments umber of patients on the "A" the unit. One LPN was so on the "A" side of the unit igned the patients on the "B" as were assigned to the "A" the unit. LPN # 24 reported if an or PICC line flush was all one of the RNs assigned to the self one of the RNs assigned those functions of patient what she would do if a unit. LPN # 24 reported 200 units would respond to un the code. LPN #24 and never checked the crash eported that was an RNs	A	386			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG_		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	03/2	0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 386	and IV push medicat 5. A review of the fact 09/04/08 to 09/26/08 deficiencies in RN staunits. On 09/04/08 from 7:0 were listed on the fact or 600 units. On 09/05/08 from 7:0 were listed on the fact 500 or 600 units. On 09/06/08 from 7:0 were listed on the fact and 600 units. On 09/07/08 from 7:0 were listed on the fact and 400 units. On 09/10/08 from 7:0 were listed on the fact unit. On 09/11/08 from 7:0 were listed on the fact unit. On 09/11/08 from 7:0 were listed on the fact unit. On 09/13/08 from 7:0 were listed on the fact or 600 units. On 09/13/08 from 7:0 were listed on the fact unit. From 7:00 PM to staffed for the 600 ur On 09/14/08 from 7:0 were listed on the fact units. On 09/15/08 from 7:0 were listed on the fact or 400 units. On 09/15/08 from 7:0 were listed on the sta On 09/18/08 from 7:0	ility's staffing records from indicated the following affing of the facility's inpatient and AM to 7:00 PM, no RNs cility staffing logs for the 500 AM to 7:00 PM, no RNs cility staffing logs for the 400, and to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 300 AM to 7:00 PM, no RNs cility staffing logs for the 500 AM to 7:00 PM, no RNs cility staffing logs for the 500 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 PM, no RNs cility staffing logs for the 400 AM to 7:00 AM, no RNs were	A	386			
	were listed on the sta	affing logs for the 400, 500 or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		290042	B. WIN	G		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	·	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 386	were listed on the sta 600 units. On 09/20/08 from 7;0 were listed on the sta units. On 09/21/08 from 7:0 were listed on the sta units. On 09/22/08 from 7:0 were listed on the sta On 09/24/08 from 7:0 were listed on the sta and 600 units. On 09/25/08 from 7:0 were listed on the sta 600 units. On 09/26/08 from 7:0 were listed on the sta 600 units. On 09/26/08 from 7:0 were listed on the sta	0 AM to 7:00 PM, no RNs ffing logs for the 400, 500 or 0 AM to 7:00 PM, no RNs ffing logs for the 400 or 600 0 AM to 7:00 PM, no RNs ffing logs for the 300 or 400 0 PM to 7:00 AM, no RNs ffing logs for the 600 unit. 0 AM to 7:00 PM, no RNs ffing logs for the 300, 500 0 AM to 7:00 PM, no RNs ffing logs for the 500 and 0 Am to 7:00 PM, no RNs ffing logs for the 400 and RN was being orientated to	A	386			
A 392	sufficient number of simplement patient foo would provide qualified organizations mission provided, the populat state certification and 482.23(b) STAFFING. The nursing service in numbers of licensed in practical (vocational) to provide nursing can there must be supers	the facility will provide a staff to successfully sused functions. The facility ed personnel based on the n, scope of services ion served, and federal and licensure requirements.	Α	392			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/2	26/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	·	2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE B VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 392	nurse for bedside carrives and on observation of any patient. Findings Include: 1. On 09/23/08 through a signed and observed assigned and observed and on duty at all time units of the facility. There were and on duty at all time units of the facility of were observed making directing patient carrows in the day and the company of the patients. 2. On 09/24/08 at 1: Nursing (DON) reported the patient of the day are been utilized as chapast 2 1/2 years. The assigned an RN as a cuity of the patients. The Acting DON reported the patients.	ate availability of a registered are of any patient. not met as evidenced by: on, interview and document iled to ensure there were Nurses (RN) assigned to obtain who were physically apervision and the immediate stered Nurse for bedside care agh 09/26/08 during the day attical Nurses (LPNs) were red functioning as charge or 100, 500 and 600 units of the no RNs physically present these on the 400, 500 and 600 uring the day shift. The LPNs and patient assignments and the without supervision from an int on the units. 20 PM, the Acting Director of orted the LPNs were and utilized as lead or charge and utilized as l	A	392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	5	STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 392	600 units to perform scope of practice of the scope of the sco	nursing functions outside the he lead LPNs such as PICC I central catheter) line flushes push medication orted she was not aware RNs obysically present on each supervise and be available for are of patients. The Acting were usually not staffed on units of the facility. 30 AM, LPN # 24 the day shift lead and 500 unit of the facility LPN her responsibility to assign LPNs and Certified Nurse signed to work on the unit. he patient assignments were or diagnosis. Assignments umber of patients on the "A" he unit. One LPN was so on the "A" side of the unit igned the patients on the "B" as were assigned to the "A" hit. LPN # 24 reported if an or PICC line flush was all one of the RNs assigned those functions of patient what she would do if a unit. LPN # 24 reported RNs units would respond to the	A 39	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING	 	09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 1770 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 392	charge nurse for the #25 reported her respatient assignments transcribing physicial patient assignments diagnosis but on nurside or "B" side of the were assigned to the unit. LPN #25 confirmor present on the 60 patient care or to masupervisor or RN has perform nursing fund practice for an LPN sand IV push medicated. 5. A review of the factor of the	the day shift lead and 600 unit of the facility. LPN ponsibilities included making directing patient care and n orders. LPN #25 reported were not based on acuity or other of patients on the "A" e unit. An LPN and a CNA e "A" side and "B" side of the med no RNs were assigned 0 unit to supervise or direct the patient assignments. A d to be called to the unit to such as PICC line flushes	A 392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	•	217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 392	unit. On 09/11/08 from 7:1 were listed on the far or 600 units. On 09/12/08 from 7:1 were listed on the far or 600 units. On 09/13/08 from 7:1 were listed on the far unit. From 7:00 PM to staffed for the 600 units. On 09/14/08 from 7:1 were listed on the far or 400 units. On 09/15/08 from 7:1 were listed on the stafon 09/18/08 from 7:1 were listed on the stafon units. On 09/19/08 from 7:1 were listed on the stafon units. On 09/20/08 from 7:1 were listed on the stafon units. On 09/21/08 from 7:1 were listed on the stafon 09/22/08 from 7:1 were listed on the stafon 09/24/08 from 7:1 were listed on the stafon 09/24/08 from 7:1 were listed on the stafon 09/25/08 from 7:1 were listed on the stafon 09/25/08 from 7:1 were listed on the stafon 09/26/08 from 7:1 were listed 09/26/08 from 7:1	200 AM to 7:00 PM, no RNs cility staffing logs for the 500 and to 7:00 PM, no RNs cility staffing logs for the 400 and to 7:00 PM, no RNs cility staffing logs for the 400 o 7:00 AM, no RNs were	A	392			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		290042	B. WING	3		09/26/2008		
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2170	T ADDRESS, CITY, STATE, ZIP CODE EAST HARMON AVENUE VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
A 392	sufficient number of simplement patient for would provide qualifications mission the population server certification and licen 482.23(b)(3) RN SUFCARE A registered nurse mather nursing care for each the nursing care for each the server of	staffing policy and I the facility will provide a staff to successfully cused functions. The facility ed personnel based on the n,scope of services provided, d, and federal and state sure requirements. PERVISION OF NURSING		392	DEFICIENCE			
	when appropriate for #10, #18, #20, #22, # Findings include: On 09/23/08 through shift, Licensed Pract assigned and observlead nurses on the 4 facility. There were non duty at all times o of the facility during tobserved making pat directing patient care RN physically preserved. 1. Patient # 6 was additional expenses.	09/26/08 during the day cical Nurses (LPN) were wed functioning as charge or 00, 500 and 600 units of the o RNs physically present and in the 400, 500 and 600 units he day shift. The LPNs were cient assignments and without supervision from an						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING	I ` '	(X3) DATE SURVEY COMPLETED	
		290042	B. WING	<u> </u>	09/2	26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIF 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	, CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE	
A 395	the patients chart or to the patients chart or to the patient she could not for Patient #6. Charginursing care plan for been completed. The was the RN responsiplans on patients addressed to the patients and the patients and the patients chart of the patient she could not for Patient #9. 3. Patient #18 was and 08/23/08 at 4:00 If reported she could not for Patient #9. 3. Patient #18 was and 09/13/08 with diagnor patient #18. Atrial Decubitus Stage II UI was located in the patients nursing care bir on 09/24/08 at 2:00 If she could not locate and patient #18. LPN #27 responsibility to initiating plans on the patients were no RNs staffed.	us Post Exploratory ing care plan was located in he units nursing care binder. PM, Charge Nurse #26 ot locate a nursing care plan e Nurse #26 indicated a Patient #6 must not have e Charge Nurse reported it bility to initiate nursing care nitted to the facility on uses including Respiratory hronic Obstructive Pneumonia and rsing care plan was located or the units nursing care PM, Charge Nurse #26 ot locate a nursing care plan dmitted to the facility on uses including Clostridium Fibrillation and Gluteal cer. No nursing care plan tients chart or the nursing	A 3	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 395	09/03/08 with diagno Abdominal Wound In Disease. Physician of included Lantus insulatevery evening and Topatients nursing care elimination" and "altered levels" were left bland the nursing staff. On 09/23/08 at 3:45 or reported nursing care the end of each shift Charge Nurse #26 in Patent #10 should had charge nurse. 5. Patient #20 was at 09/17/08 with diagno Obesity, Atrial Flutter and Bilateral Knee Rorders dated 09/21/0 Foley catheter and bin nursing care plan und and "alteration in care with no entries filled of the condens of the patients nursing volume deficit" and "aleft blank with no entriestaff.	dmitted to the facility on ses including Diabetes, fection and End Stage Renal rders dated 09/22/08 lin 15 units subcutaneously otal Parental Nutrition. The plan under "alteration in bration in blood glucose k with no entries filled out by PM, Charge Nurse #26 e plans are updated daily at when chart checks are done. Indicated the care plan for ave been updated by the	A 395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 395	for initiating a nursing admitted to the facility care plan to address expected outcomes, Licensed Practical N care plan when appropriate The Acting DON acknown were utilized as chare 500 and 600 units in basis they would not plans on patients and Acting DON acknown supervising and eval patients on the above facility. The Acting Daware a Registered I present on each unit ongoing assessment 7. Patient #29 was a 9/20/08 with diagnos Failure on dialysis, C Bacteremia, Chronic Effusion. Review of Patient #2 included a urinalysis (UA with C/S). Review on 9/22/08 at 12:28 I written for "Stool for occ Certified Nurses Ass On 9/25/08 at 8:00 A C/S and Stool for occ Certified Nurses Ass	ted RNs were responsible g care plan on each patient y and updating the nursing any new patient problems, goals and interventions. urses may add to the nursing opriate. nowledged that since LPNs ge nurses on the 300, 400, the facility on a frequent be initiating nursing care mitted to those units. The edged lead LPNs were uating nursing care to e mentioned units of the DON reported she was not Nurse must be physically of the facility to provide s and care of patients. dmitted to the facility on es including Acute Renal coagulase-Positive Anemia and Pleural 9's admission orders with culture and sensitivity ew of the physician's orders PM revealed, an order was	A	395			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAE	BILITATION HOSPITAL	,	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	1 00/2	9. 2 000
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	specimens were collaboratory. Employee #22 furth to re-write the order sent after two days simply remind the sheen carried out. On 9/25/08 at 8:20 the charge nurses where all orders were Employee #21 furth make sure specimed due to: The laboratory reconstruction of the charge nurses of the control of t	er revealed, physicians were if the specimens were not of the original order, and/or to taff the original order had not AM, Employee #21 revealed, were responsible in making carried out. er revealed, it was difficult to ns were collected by CNAs quisitions were given to the requisition forms until the	A	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		290042	B. WIN	IG		09/26/2008		
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO THE DEFICIENCY		ION SHOULD BE THE APPROPRIATE		
A 395	Continued From page	e 81	А	395				
	on 9/18/08.	r occult blood was ordered						
	admitted Patient #34 was no documentation	M, Employee #25 who to the unit revealed, there in nor any endorsement that b be checked for occult						
	Employee #25 added told about needing st	, " I got report but I was not ool for occult blood."						
	there was no docume	M, Employee #25 revealed, entation in the patient's ided stool specimen for						
	the stool sample had #25 further indicated	M, Employee #25 revealed, not been sent. Employee the physician had made to "make sure it gets done."						
	9/9/08 with diagnose Disease, Obstructive	Imitted to the facility on s including Chronic Kidney Uropathy, Status Post my and Resection, and ma.						
		M, a requisition for stool for found in the Certified Nurses der.						
	The order was writter	n on 9/22/08 at 12:40 PM.						
	movement (BM) with	ed, Patient #35 had a bowel n the morning shift x1, once and once within the night						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	Continued From page	e 82	А	395			
		M, Employee #22 revealed, and a bowel movement for 4					
	notes indicating Patie	was shown the nurses ent #35's BMs, Employee e CNAs were responsible in ens were collected.					
	Employee #22 also revealed, if the specimens were not sent after two days of the original order was made, the physicians were to re-write the order and/or to simply remind the staff that the original order had not been carried out.						
A 396	Director of Nursing re	AM, interview with the Acting evealed, there was no policy ble for specimen collection. IG CARE PLAN	A	396			
	•	sure that the nursing staff current, a nursing care plan					
	Based on interview at failed to ensure the n kept current a nursing	not met as evidenced by: nd record review, the facility ursing staff developed or g care plan for 7 out of 36 , #18, #20, #21, #24).					
	Findings include:						
	08/20/08 with diagnost Pain, Peritonitis, State Laparotomy. No nurs	mitted to the facility on ses including Abdominal us Post Exploratory sing care plan was located in he units nursing care binder.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG	 	09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119	1 00,2	5/ 2 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 396	On 09/23/08 at 4:00 reported she could n for Patient #6. Charnursing care plan for been completed. The was the Registered I initiate nursing care admitted to the facilitiate nursing care of the patient #9 was accompleted she could not not not patient #9. 3. Patient #18 was accompleted she could not not patient #9. 3. Patient #18 was accompleted she could not not patient was located in the patient she could not locate patient #18. LPN #2 Registered Nurses reupdate nursing care was affed on the unit or nursing care plan for 4. Patient #10 was accompleted was accompleted was accompleted she could not locate patient #18. LPN #2 Registered Nurses reupdate nursing care plan for 4. Patient #10 was accompleted was accompleted was accompleted was accompleted with the patient was ac	PM, Charge Nurse #26 ot locate a nursing care plan ge Nurse #26 indicated a Patient #6 must not have charge Nurse reported it Nurses responsibility to plans on patients who are ty. dmitted to the facility on pses including Respiratory Chronic Obstructive Pneumonia and rising care plan was located or the units nursing care PM, Charge Nurse #26 ot locate a nursing care plan dmitted to the facility on pses including Clostridium Fibrillation and Gluteal licer. No nursing care plan atients chart or the nursing inder. PM, Lead LPN #27 reported a nursing care plan for reprincipated it was the esponsibility to initiate and plans on the patients. LPN vere no Registered Nurses in day shift who could initiate a	A	396			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE			
A 396	Disease. Physician included Lantus insulevery evening and T patients nursing care elimination" and "alte levels" were left blanthe nursing staff. On 09/23/08 at 3:45 reported nursing care the end of each shift Charge Nurse #26 in Patent #10 should had charge nurse. 5. Patient #20 was a 09/17/08 with diagnod Obesity, Atrial Flutte and Bilateral Knee Rorders dated 09/21/0 Foley catheter and be nursing care plan unand "alteration in carwith no entries filled 6. Patient #21 was a 9/3/08 with diagnose Obstructive Pulmonal Heart Failure and Chanursing care plan and chronic back pain. 7. Patient #24 was a 09/03/08 with a diagnose obstructive Pulmonal Heart Failure and Chanursing care plan and chronic back pain.	Infection and End Stage Renal porders dated 09/22/08 lin 15 units subcutaneously otal Parenteral Nutrition. The explan under "alteration in teration in blood glucose k with no entries filled out by the plans are updated daily at when chart checks are done. dicated the care plan for ave been updated by the did to the facility on ses including Morbid r, Hypertension, Bronchitis eplacements. Physicians included discontinuing the ladder training. The patients der "alteration in elimination" diac output" were left blank out by the nursing staff.	A	396				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	s	STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 396 A 397	The patients nursing volume deficit" and "a left blank with no enti staff.	Clostridum Difficile Colitis. care plan under "fluid alteration in elimination" were ries filled out by the nursing	A 39			
A 397	A registered nurse m of each patient to oth accordance with the	ust assign the nursing care ler nursing personnel in patient's needs and the lions and competence of the e.	A 38			
	Based on observation failed to ensure a Re nursing care of each personnel according	not met as evidenced by: n and interview the facility gistered Nurse assigned the patient to other nursing to the patients needs and I competence of the nursing				
	shift, Licensed Pract assigned and observed lead nurses on the 40 facility. There were rephysically present and 400, 500 and 600 uniday shift. The LPNs patient assignments without supervision frephysically present on	gh 09/26/08 during the day ical Nurses (LPNs) were yed functioning as charge or 00, 500 and 600 units of the no Registered Nurses id on duty at all times on the its of the facility during the were observed making and directing patient care from a Registered Nurse is the units.				
	Nursing (DON) report frequently assigned a					

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	09/20	6/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 397	been utilized as char past 2 1/2 years. The assigned a Registered due to the high acuit units. The Acting DON repincluded making patidirecting patient care were responsible for Certified Nurse Assis or "B" side of each us 600 units. The patie on numbers of patient qualifications and costaff. Supervisors a called to the 300, 40 perform nursing function practice of the lead Leand IV (intravenous) administration. The Acting DON repropersent on each unit make patient assignification and responsible for Certified Nurses were present on each unit make patient assignification and IV (intravenous) administration. The Acting DON repropersent on each unit make patient assignificate bedside of DON confirmed Regroot staffed on the 40 facility. The Acting I with the staffing coor LPNs and CNAs to tit was left to the lead assignments on the 3. On 09/25/08 at 10	d night shifts. The LPNs had ge nurses for at least the e 100 and 200 units were ed Nurse as charge nurse y of the patients on those orted the lead LPNs duties ent assignments and e on the units. The lead LPNs assigning other LPNs and stants (CNAs) to an "A" side nit on the 300, 400, 500 and not assignments were based not not not acuity, diagnosis or impetence of the nursing not Registered Nurses were 0, 500 and 600 units to tions outside the scope of LPNs such as PICC of central catheter) line flushes push medication orted she was not aware vere required to be physically of the facility to supervise, ments and be available for the facility to supervise, ments and the facility to supervise, ments are the facility to supervise and the facility to supervise, ments are the facility to sup	A	397			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	, , ,	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 397	#24 reported it was he patients to the other leads work on the unit. LPI assignments were not diagnosis. Assignments of the unit. One LPN were unit. One LPN were assigned to the LPN #24 reported if a PICC line flush was reported if the Registered Nurse unit, or a supervisor perform those function confirmed Registered patient assignments was asked what she on her unit. LPN #24 from the 100 or 200 to emergency and run til.	er responsibility to assign LPNs and CNAs assigned to N #24 reported the patient but based on acuity or ents were based on the in the "A" side and "B" side of as assigned the patients on it and an LPN was assigned but based of the unit. CNAs "A" and "B" side of the unit. an IV push medication or needed she would call one of the sassigned to the 100 or 200 to respond to the unit to the soft patient care. LPN #24 but Nurses did not make the con the 500 unit. LPN #24 but would do if a patient coded but reported Registered Nurses units would respond to the the code. LPN #24 and never checked the crash eported that was a	A 39				
	charge nurse for the #25 reported her resp patient assignments, transcribing physician patient assignments diagnosis but on num side or "B" side of the were assigned to the unit. LPN #25 confirm	the day shift lead and 600 unit of the facility. LPN consibilities included making directing patient care and n orders. LPN #25 reported were not based on acuity or other of patients on the "A" e unit. An LPN and a CNA "A" side and "B" side of the med no Registered Nurses sent on the 600 unit to					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
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OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	170 EAST HARMON AVENUE	,	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
supervise or direct p patient assignments. Nurse had to be calle nursing functions out an LPN such as PICO medication administra 5. On 09/23/08 throug patient assignment sl 600 units of the facilit filled out the assignment the nursing staff assig on the units. 482.23(c) ADMINIST Drugs and biologicals administered in accord State laws, the orders practitioners respons specified under §482 standards of practice This STANDARD is Based on observation review, the facility fail orders for 3 of 36 pat Finding include: 1. Patient #31 was ac 9/18/08 with diagnose Status Post Respirate Syndrome, Addison's Pain. On 9/21/08, a physici receive K-Dur (potass	atient care or to make A supervisor or Registered and to the unit to perform side the scope of practice for C line flushes and IV push ation. gh 09/26/08, a review of the heets on the 300 through by indicated the lead LPNs ent sheets and documented gnments on a bulletin board RATION OF DRUGS Is must be prepared and redance with Federal and so of the practitioner or lible for the patient's care as an accepted. Inot met as evidenced by: In, interview and record led to follow physician's lients (#31, #32, #33). Idmitted to the facility on les including Hypokalemia, by Failure, Cushings and Disease and Chronic Back Is an ordered for Patient #31 to sium chloride supplement)					
	CORRECTION COVIDER OR SUPPLIER MEDICAL AND REHABI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page supervise or direct p patient assignments. Nurse had to be calle nursing functions out an LPN such as PICC medication administra 5. On 09/23/08 throug patient assignment st 600 units of the facilit filled out the assignment the nursing staff assignon the units. 482.23(c) ADMINIST Drugs and biologicals administered in accord State laws, the orders practitioners respons specified under §482 standards of practice This STANDARD is Based on observation review, the facility fail orders for 3 of 36 pat Finding include: 1. Patient #31 was ac 9/18/08 with diagnose Status Post Respirate Syndrome, Addison's Pain. On 9/21/08, a physici receive K-Dur (potass 10 mEq (milliequivale	OVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 supervise or direct patient care or to make patient assignments. A supervisor or Registered Nurse had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes and IV push medication administration. 5. On 09/23/08 through 09/26/08, a review of the patient assignment sheets on the 300 through 600 units of the facility indicated the lead LPNs filled out the assignment sheets and documented the nursing staff assignments on a bulletin board on the units. 482.23(c) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physician's orders for 3 of 36 patients (#31, #32, #33). Finding include: 1. Patient #31 was admitted to the facility on 9/18/08 with diagnoses including Hypokalemia, Status Post Respiratory Failure, Cushings Syndrome, Addison's Disease and Chronic Back	OVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 supervise or direct patient care or to make patient assignments. A supervisor or Registered Nurse had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes and IV push medication administration. 5. 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On 9/21/08, a physician ordered for Patient #31 to receive K-Dur (potassium chloride supplement) 10 mEq (milliequivalent) PO (by mouth) everyday.	OVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 supervise or direct patient care or to make patient assignments. A supervisor or Registered Nurse had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes and IV push medication administration. 5. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 404	(milliequivalent/liter). On 9/25/08, review of Administration Record #31 received the first 9:00 AM. On 9/25/08 at 8:30 And there was no docume #31 received the first opposed to 9/21/08. 2. Patient #32 was a 9/18/08 with diagnost Obstructive Pulmonal Accident with Right Dysphagia, Status Poet Endoscopic Gastrost On 9/25/08 at 11:10 administration record #32's Theophylline 8 centimeter) was due had not been given at On 9/25/08 at 11:10 revealed, Patient #32 due at 9:00 AM. The given at 11:10 AM. On 9/25/08 at 11:10 AM. On 9/25/08 at 11:10 at	f the Medication d (MAR) revealed, Patient dose of K-Dur on 9/23/08 at M, Employee #9 revealed, entation as to why Patient dose of K-Dur on 9/25/08 as dmitted to the facility on es including Chronic ry Disease, Cerebrovascular Sided Hemiparesis, Chronic ost Percutaneous omy (PEG). AM, review of the medication (MAR) revealed, Patient 0 mg (milligram)/15 cc (cubic at 9:00 AM. The medication	A 404			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG		09/2	6/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CO 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
A 404	PEG tube and had be through it, since the dysphagia. The Prilip medication that could on 9/25/08 at 10:34 contract pharmacy rewas re-ordered for PO 9/25/08, review of "Medications Not To one of the medication." 3. Patient #33 was a 9/17/08 with diagnost and Status Post Left On 9/25/08 at 8:15 A Employee #10 did not mouth and Fish Oil 1 #33. Upon medication presented in the medication according to the medication accor	er revealed, Patient #32 had a een receiving the medication patient had chronic osec tablet was one d not be given crushed. AM, a faxed receipt for the evealed, the Theophylline atient #32. If the facility's list of Be Crushed", Prilosec was ns listed. Idmitted to the facility on rese including Osteoarthritis Total Knee Arthroplasty. In during medication pass, of give Niacin 500 mg by 000 mg by mouth to Patient I reparation for Patient #33, observed circling her initials diministration record (MAR) to ications, prior to going to I m. Employee #10 revealed, in refusing to take the Niacin at least a week. I ted in the past, Patient #33 ent would resume the	A	404				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	•	STREET ADDRESS, CITY, STATE, ZIP CO 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE AT CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	CTION SHOULD BE THE APPROPRIATE	
A 404	physician had been in medication refusal. On 9/25/08 at 8:30 Ashe was not aware on Niacin and Fish Oil to Employee #9 further patient was refusing have notified the physical three patient had refuse the patient had refuse on 9/25/08, Patient administration record not been taken since tablet had not been to Niacin 500 mg by moon 9/17/08. Fish Oil also ordered on 9/17/482.23(c)(2) WRITTI DRUGS With the exception of pneumococcal polysmay be administered hospital policy after a contraindications, or must be documented who is authorized to policy and in accordance.	and sure if the attending notified of patient's continued and, Employee #9 revealed, of Patient #33's refusal to take ablets. stated, "I was not aware the the medications. I would resician from the very first day ed." #33's medication and (MAR) revealed, Niacin had en 9/21/08, and the Fish Oil aken since 9/17/08. Bouth (PO) daily was ordered and 1000 mg PO twice a day was 1/08. EN MEDICAL ORDERS FOR and signed vaccines, which are physician-approved an assessment of ders for drugs and biologicals and signed by a practitioner write orders by hospital ance with State law, and who are care of the patient as		404			
	Based on record rev comply with the med	not met as evidenced by: iew, the facility failed to ical staff bylaws which d verbal orders were to be					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		` ÍDENTIFICATION NUMBER:		JLTIPL .DING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/2	26/2008
	OVIDER OR SUPPLIER	BILITATION HOSPITAL	·	217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE IS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 406	Findings include: 1. On 9/24/08, the findings include: 1. On 9/24/08, the findings include: 1. On 9/24/08, the finding prace and finding praces and finding praces. 1. On 9/24/08 at 12 with and Medicare Service. 1. On 9/14/08 at 12 with and Medicare Service. 1. On 9/14/08 at 12 with and Medicare Service. 1. On 9/14/08 at 12 with and Medicare Service. 2. On 9/14/08 at 12 with a with N.S. (normal single service). 3. On 9/14/08 at 3 with a w	dering practitioner within 48 atients (#12). Following verbal orders for bund and were not signed off citioner. These orders our CMS (Center for Medicaid ices) requirement. PM: "Lortab 5/500mg PO (by mouth) every 4 hours or pain." indicated): "Change right heel aline) Pat dry. Wrap with ay) by nursing." PM, the Acting Director of the physicians normally signed and verbal orders the next day are given. The two orders were	A	406			
A 494	482.25(a)(3) PHAR Current and accura receipt and distribu This STANDARD i	te records must be kept of the tion of all scheduled drugs. s not met as evidenced by: , the hospital failed to keep a	A -	494			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	G		09/2	6/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	•	217	ET ADDRESS, CITY, STATE, ZIP CODE O EAST HARMON AVENUE S VEGAS, NV 89119	, 30.2	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
A 494	current and accurate scheduled drugs, froi hospital to the point of Findings include: On 9/23/09 at 9:30 A Pharmacist revealed - There was no policy place to ensure disposaccurate from the timendorsed to the hospital endorsed	tracking system of all method the point of entry into the of disposal. M, interview with the hospital the following: A and procedure currently in osal of scheduled drugs were see the scheduled drugs were sital Pharmacist for disposal. Form was the "LTC (Long and Substance Destruction adicate, narcotic medications and back to the contract stion. This form was signed and Director of Nursing. A acist transported the for disposal to the for disposal to the for disposal to the for disposal to the form were transported via the form of the narcotic medications were accounted the form of the narcotic medications were accounted the form of signature form which spital by the Pharmacist and	A	494				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	ILITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 494	by a representative of the policy and procedure was currently in place narcotics were taker returned to contracte practice were as follows. When a patient's nedication was pulled and collected by the contracted pharmac. The medication was office, in a locked cathe hospital Pharmac contracted pharmac. The Pharmacist and Assistant Director of narcotic medications delivery to contracte. It was to the hospit discretion when schedelivered back to contracted pharmac. Once all narcotic mand accounted for be delivered for bursely of the process of the policy of the process of the policy of the process of the policy of	I Pharmacist and co-signed of contracted pharmacy. PM, interview with the Acting DON) revealed, there was no e nor a tracking process that ee, when discontinued nout of the facility to be ed pharmacy. The hospital's lows: arcotic medication had been or her physician, the ed from the pyxis machine DON. Is then kept in the DON's abinet until it was collected by cist for return to the last of accuracy prior to its depharmacy for disposal. All Pharmacist's or the DON's eduled drugs were to be intracted pharmacy. Indeed every month to two on the volume of narcotics to facted pharmacy for disposal. Intelligence of the pharmacist and each controlled drug drugs were reconciled by the hospital Pharmacist and each controlled drug	A	494			

STATEMENT OF DEFICIENCIES (X*) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	3072	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE	
A 494	the patient's medical - The "LTC Controller Signature Form" was Pharmacist and the I which was given to the upon delivery of the s form was in turn, sign representative of the - The narcotic medicat tamper-proof plastic contracted pharmacy contacted the pharmacy contacted the pharmacy contacted the pharmacy day's delivery, and a the travel time did no - There was no log ke than the controlled di which was placed in Per interviews condu have any documenta the movement of all s 482.25(b)(2)(i) SECU All drugs and biologic area, and locked whe This STANDARD is Based on observation failed to ensure all dr	OON. This form was kept in chart. d Substance Destruction initiated and signed by the OON for relinquishment, he contracted pharmacy scheduled medications. This hed off by the receiving contracted pharmacy. ations were placed in a container for delivery to the hospital Pharmacist acy to notify them of the time frame was set in which the exceed one hour. The hospital Pharmacist acy to notify them of the time frame was set in which the exceed one hour. The hospital did not the time readily available to trace scheduled drugs. TRE STORAGE TRE STORAGE The hospital did not the patient's medical chart. The hospital other rug receipt/disposition form, the patient's medical chart.		502			
	On 9/23/08, during th	e hospital tour at 8:00 AM,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING _		09/	26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	ST	TREET ADDRESS, CITY, STATE, ZIP COI 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
A 502	the refrigerator for meto be unlocked. On 9/23/08 at 8:10 A have unsecured medox. These medicatis suspension, Niaspan wax remover drops, Carvedilol. On 9/23/08 at 8:10 A the medications had awaiting to be picked disposal. Employee should have been ke against the wall, instation of 9/23/08 at 8:40 A 600 Hall was found to #18 stated, "Mainten but it's still not working trouble with that cart. On 9/23/08 at 8:50 A found at the nurses's Novolin Regular Insuition of 9/23/08 at 8:50 A Nursing (DON) stated have been locked up On 9/23/08 at 9:00 A rehabilitation department of 9/23/08 at 9:10 A therapy room, an operation of the property	M, the 500 Hall was found to dications on top of a pyxis ons were: Nystatin and Phoslo-gel capsules, ear Buproprion SR and M, Employee #16 revealed, been discontinued and were and up by a supervisor for and were and the small pyxis box alled for that purpose. M, a medication cart in the compose be unlocked. Employee ance already worked on it ang; We have been having for awhile now." M, a plastic pink tray was station with an open vial of lin dated 8/30/08. M, the Acting Director of did, the vial of Novolin should by the wooden shelf. M, inside the physical en bottle of Vitamin B6 and amin B12 tablets were found	A 50	2			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG_		09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 502	Continued From page	e 97	А	502	2		
	There were no hospit	al staff available for inquiry.					
	Chloride flush with no the bedside of Patien administrator was im	M, a syringe of Sodium eedle attached, was found at it #25. The hospital mediately made aware of the d to walk by the patient's					
	Novolin R labelled, "o	M, an unsecured open vial of open date 8/31" was found in the counter of 200 Hall					
		M, Employee #17 stated, "it's buse supply and it is for					
		M, the Acting DON walked in nade aware of the finding.					
		the vial of Novolin R and the #17 verbally instructing the s up."					
	refrigerator was obse unattended by staff. and found to contain Insulin, two vials of N R Insulin, two vials of of Humolog Insulin. Aplisol were found.	M, the 100 hall medication erved to be unlocked and The refrigerator was opened three vials of Novolog ovolin N, one vial of Novolin f Lantus Insulin and one vial in addition, two vials of					
	On 9/23/08 at 8:45 A 300 hall was found to	M, the medication cart on the be unlocked and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN			00/0	0/0000
	OVIDER OR SUPPLIER			21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	[09/20	6/2008
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 502	easily opened and paremoved. The Acting Director of the unlocked refrigeration 10:00 AM. The Acting that staff "knew better medication storage at 482.25(b)(3) UNUSAL Outdated, mislabeled drugs and biologicals patient use. This STANDARD is represented that the facility fail drugs were not available that the facility fail drugs were not available. On 9/25/08 at 3:15 Pthall crash cart was medicated that the following expired to the following expired to the following expired to the following that the following expired to the following that the following expired to the following: The 100 Hall crash to the following:	The drawers to the cart were tient's medications could be If Nursing was informed of ator and medication cart at g Director of Nursing stated than to leave the reas unlocked. BLE DRUGS NOT USED If or otherwise unusable must not be available for must not be available for the reasure all outdated ble for patient use. If of the patient use is a series of the seri		502			
	have been checked for	or complete number of					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		290042	B. WIN	IG _		09/26/2008		
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	JMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE			
A 505	night shift. - Employee #20 was shift charge nurse or charge nurse took ar - Medications to supplifications via facsile levels of each medications via facsile vels of each medications whether the or not. - Employee #20 was the par levels were or being locked at all time. On 9/25/08 at 8:25 A the following: - It was the responsitional and house supervisor medications were contained. - An inventory was memergency. This was nurse (100 or 500 Hacrash carts are located. - Missing medication medications were reprized and the house hospital's emergency medicated in the 200, 300. - The 200 and 300 H cabinets were the "medications w	ons dates. Sh cart was opened on the not sure whether the night the following day shift inventory of the crash cart. Oly the crash cart were contract pharmacy. acy was given a list of mile, to complete the par ations for the crash cart. locked at all times the par levels were complete not sure how to determine if complete due to the crash cart thes. My Employee #21 revealed whility of the unit charge nurse or to ensure the crash cart mplete and not outdated. ade soon after an sy made by the unit charge full charge nurses where ed). sy and/or outdated olenished by the charge supervisor through the or medication cabinet. dication cabinets were	A	505				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI) TAG CROSS-REFERENCED TO THE DEFICIENCY		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 505	- When medications the emergency medications the emergency medications the emergency medication cabinet (some of the contract pharman inventory and reperied medication cabinet (some of the procedure indicated, fully stocked at all time dications and supsituation. To make some working order and almedications are pulled carts". - The hospital's mainand procedure states immediately after use (some of the cart has the ca	were taken out from any of cation cabinet, the contract ed via a telephone call. acy was to come in, to make denish the emergency s). In 9/25/08: To ensure crash carts are nes with equipment plies needed in a code ure equipment is in proper so to ensure that expired ed and replaced on the crash etchance of crash cart policy s, " Carts are to be restocked e by a designated person entation found in the policy icate who the designated cured after cart has been as been fully restocked and ered lock is to be replaced flow sheet." cart was locked before it darone 150 mg/3 ml were all level, there should have 10% amp. There were	A 505			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		290042	B. WIN	G		09/26/2008	
	OVIDER OR SUPPLIER MEDICAL AND REHABII	LITATION HOSPITAL		21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 585	- Based on the par been 3 of Dopamine 4 was only one for 2008 "After the code, the and signed off by the and nurse who restocked cart was restocked cart was restocked cart was restocked Employee #20. 482.27(a)(3) WRITTE TISSUE SPECIMENS. The laboratory must reproper receipt and	ne 0.1 mg/ml. There d in the crash cart. level, there should have 400 mg/250 ml. There und and it expired in July Code Cart will be restocked House Supervisor/ADON cked." nent found indicating the ked. This was confirmed by EN PROTOCOL FOR So make provisions for the corting of tissue specimens. not met as evidenced by: policies and procedures and nical director of respiratory of nursing, the laboratory tions for the collection, rtation, receipt and reporting		585			
A 586	care on 9/23/2008 at was no provision for t tissue specimens. Th reviewing the hospita confirmed this on 9/25 482.27(a)(4) POLICIE SERVICES	ES FOR LABORATORY	A	586			
	The medical staff and	a pathologist must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/20	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		.D BE	(X5) COMPLETION DATE
A 592	macroscopic (gross) require both macroscopic examinations. This STANDARD is Based on a review of the clinical director of director of nursing, the approved by the med determine which tissus macroscopic and white macroscopic and mice. The findings include: There was no written tissue specimens. The interviews with the clicare on 9/23/2008 at of nursing on 9/25/20482.27(b) POTENTIABLOOD/BLOOD PROSTANDARD Standard: Potentially products. (1) Potentially human (HIV) infectious blood Potentially HIV infectious potentially HIV infections of the product of a later donation; (ii) Who tests positic (additional, more spetesting required by FI	not met as evidenced by: policies and interviews with respiratory care and the ere were no policies ical staff and a pathologist to ue specimens require a ch require both a croscopic examinations. policy for the examination of is was confirmed by inical director of respiratory 2:00 p.m. and the director 08 at 9:35 a.m. ALLY INFECTIOUS DDUCTS reinfectious blood and blood in immunodeficiency virus and blood components. ious blood and blood collections from a donor - gative at the time of donation evidence of HIV infection on ive on the supplemental cific) test or other follow-up DA; and ming of seroconversion		592			
	carniot be precisely e	ouriatou.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE
A 592	Continued From pag	e 103	A 592			
	(2) Potentially hepati blood and blood cominfectious blood and blood come 610.47. (3) Services furnished collecting establishment, it must the blood collecting establishment, it must the blood collecting establishment, training the procurement, training the procurement that the establishment notify (i) Within 3 calent collecting establishment collecting establishment notify components collected negative at the time for evidence of HIV of donation or who is detailed.	tis C virus (HCV) infectious apponents. Potentially HCV blood components are the apponents identified in 21 CFR d by an outside blood lent. If a hospital regularly an outside blood collecting at have an agreement with lestablishment that governs ansfer, and availability of apponents. The agreement blood collecting the hospital — dar days if the blood lent supplied blood and blood d from a donor who tested of donation but tests reactive or HCV infection on a later etermined to be at increased				
	(ii) Within 45 days the supplemental (ac for HIV or HCV, as retesting required by F (iii) Within 3 calencollecting establishm components collecte whenever records ar CFR 610.48(b)(3). (4) Quarantine of blopending completion of collecting establishm an agreement) notific HIV or HCV screening the supplemental for the supplemental forms of the supplemental	and blood components of testing. If the blood ent (either internal or under esthe hospital disposition of the blood or the blood or the blood or the blood of the blood ent supplied blood and blood disposition of the blood ent (either internal or under esthe hospital disposition of the blood or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE .AS VEGAS, NV 89119	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TH DEFICIENCY		SHOULD BE	(X5) COMPLETION DATE	
A 592	blood components from inventory. (i) If the blood conthe hospital that the record in a continuous content in the properties of the the propertie	d quarantine all blood and om previous donations in allecting establishment notifies result of the supplemental ecific) test or other follow-up DA is negative, absent other ts, the hospital may release components from quarantine. Electing establishment notifies result of the supplemental ecific) test or other follow-up DA is positive, the hospital the blood and blood ransfusion recipients as set 10(6) of this section. Electing establishment notifies result of the supplemental ecific) test or other follow-up DA is indeterminate, the or label prior collections of conents held in quarantine as 10.46(b)(2), 610.47(b)(2), and the hospital. The hospital esource and disposition of all bood components for at least the of disposition in a manner etrieval; and plan to transfer these records of other entity if such hospital any reason.	A 592				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		290042	B. WING		09/26/2008		
	ROVIDER OR SUPPLIER	BILITATION HOSPITAL	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119		720/2000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 592	through its own blocunder an agreemen blood components to individual, the hospin actions: (i) Make reasonapatient, or to notify to ordered the blood on the physician to notification as permitted this section, that poinfectious blood or to transfused to the paneed for HIV or HCV (ii) If the physicial make the notification to give this notification to give this notification are defined in the notification or at notification. (7) Timeframe for notification. (7) Timeframe for notification or at notification or at notification. (7) Timeframe for notification or at notification or at notification. (7) Timeframe for notification or at notification or at notification. (7) Timeframe for notification or at notification effort be establishment notification effort be establishment notification effort be establishment attempts period of 12 weeks (A) The patien (B) The hospin patient and docume record the extenuation.	conents (either directly of collecting establishment or to or released such blood or or another entity or appropriate tal must take the following able attempts to notify the he attending physician who is blood component and ask for the patient, or other sed under paragraph (b)(10) of other tally HIV or HCV blood components were tient and that there may be a value tient and that there may be a value tient and that there may be a value tient and that there may be a to testing and counseling. In is unavailable or declines to on, make reasonable attempts on to the patient, legal the patient's medical record tempts to give the required of the patient's medical record tempts to give the patient's medical record tempts to give the required of the patient's medical record tempts to give the patient's medical record tempts to give the required of the patient's medical record tempts to give the required	A 592				

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/:	26/2008
	ROVIDER OR SUPPLIER	SILITATION HOSPITAL	•	2170	T ADDRESS, CITY, STATE, ZIP CODE EAST HARMON AVENUE S VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 592	2008. For notification February 20, 2008 at 610.48(b) and (c), the when the blood collection to be infectious blood and hospital must make notification and must 1 year of the date on notification from the establishment. (8) Content of notificinclude the following (i) A basic explainment of the decision of the decision of the decision to obtain HIV or HC (iii) A list of prograperson can obtain From the prograph of the	If 12 weeks. Isted before February 20, ons from donors tested before its set forth at 21 CFR in enotification effort begins ecting establishment notifies eceived potentially HCV blood components. The reasonable attempts to give it complete the actions within in which the hospital received outside blood collecting eation. The notification must information: ination of the need for HIV or curseling. In written information so that in can be made about whether of testing and counseling. In the counseling in the coun	A	592			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 592	behalf, the physician patient or his or her I relative. For possible recipients that are de hospital must inform representative or relaminor, the parents or notified. (11) Applicability. Horesulting from donors 2008 as set forth at 2 August 24, 2015. This STANDARD is Based on review of pinterviews with the diinservice/infection copolicies or procedure take appropriate acties.	e information on the patient's or hospital must notify the egal representative or HIV infectious transfusion oceased, the physician or the deceased patient's legal ative. If the patient is a legal guardian must be EV notification requirements a tested before February 20, et CFR 610.48 will expire on the motion of the motion of the motion of the motion of the motion when notified that blood in it received are at risk of	A	592			
A 593	at 9:35 AM, stated the place to notify recipied infectious blood or blood confirmed by the insection who was interviewed 482.27(c) GENERAL General blood safety activities only related that are identified after must comply with FD	ng interviewed on 9/25/2008 e hospital had no system in ents of receiving potentially cood components. This was ervice/infection control nurse on 9/25/2008 at 10:00 AM. BLOOD SAFETY ISSUES issues. For lookback to new blood safety issues er August 24, 2007, hospitals A regulations as they pertain is in the following areas:	A	593			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		290042	B. WINC	·		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE S VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 593	Continued From page	e 108	A 5	593			
	infectious blood and I (2) Notification and c	ng and quarantining of blood components. counseling of recipients that fectious blood and blood					
	Based on review of p interviews with the di inservice/infection co policies or procedure take appropriate action	not met as evidenced by: olicy and procedures and rector of nursing and the ntrol nurse, there are no s in place for the hospital to on when notified that blood it received are at risk of CV.					
A 621	at 9:35 AM stated the place to notify and correceiving potentially is components. This was inservice/infection cointerviewed on 9/25/2 482.28(a)(2) QUALIF. There must be a qual part-time, or on a control of the state of the procedures, the facilities and the place of the place	ntrol nurse who was 2008 at 10:00 AM. IED DIETITIAN iffied dietitian, full-time, isultant basis. not met as evidenced by:	A 6	521			
	rinaings include:						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WIN	G		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
A 621	within 72 hours a pati determine if there we did not address the a that may require nutri screening services pr admitted to the hospit	on for New lated 3/2006 revealed that ent would be visited to re special needs. The policy cute care hospital patient tion assessment or ior to three days after being tal.		621			
A 622	There must be admin personnel competent This STANDARD is a Based on observation ensure the hospital kindle clean and sanitary material states and sanitary sanitar	kitchen the following fied: n, observed one dietary shes from the breakfast was wearing plastic gloves. orking alone in the dish employee was observed nes, clearing, stacking and o a tray for washing and an dishes from the tray wes or washing his hands. Served twice before the vened and asked the his gloves between touching lishes.	A	622			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		290042	B. WING	i	0.9	/26/2008
	OVIDER OR SUPPLIER	BILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CC 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		72072000
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 622	Continued From page	ge 110	A 6	22		
	resealed or dated at	non pudding mix was not fer it was opened. mount of water on the floor in om. Staff had placed a				
	blanket on the floor	to absorb the water rather atter to drain properly into the				
A 749	dirt and debris had	a-in freezer had broken tiles, accumulated in this area. TION CONTROL OFFICER	A 7	49		
	develop a system fo	I officer or officers must or identifying, reporting, ontrolling infections and ases of patients and				
	Based on observation failed to ensure the	s not met as evidenced by: on and interview, the facility maintenance of a sanitary nt to control infections and and personnel.				
	Findings included:					
		AM, a tour of the facility was owing observations were				
	was observed stuck Two stained 2x2 dre shower room floor. - Two pairs of used	to the inside of a toilet essings were seen lying on the discarded gloves, plastic ed Posey vest were located				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL		21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 749	brown dirt stains and shower area. - The room was clutt including numerous of tables and infection of large plastic bag, a psheets were observed. - An empty bleach bot trash was observed of the An empty bleach bot trash was lying on the An empty bleach bot lying on top of a cour. - A tan colored sticky by two dialysis mach. 4. In the laundry room hallway of the facility a trash container and inside the doorway. - Black streaks, brow covered the floor by water soaked bed consaturated towels were water behind one of	wer room was filthy with foot prints throughout the ered with equipment wheel chairs, shower chairs, control carts. Oplies which included boxes were lying on the floor by ontained shelves stocked read, clean disinfected om located on the 100 hall a lair of latex gloves and two d lying on the floor. Ilocated between the 100 and orage of dialysis machines, overflowing from a trash bag. Ottle, used gloves, and plastice efloor. Ottle and a used glove was inter top.	A	749			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		290042	B. WIN	IG		09/20	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		D BE	(X5) COMPLETION DATE
A 749	water behind one of to store dialysis and was overflowing out door. - Dirt and dust cover room. - A fine layer of dust that were stored on a six inches from the fl 6. In the rehabilitation washing machine, br located around the p washer. - Wet pads were left On 09/23/08 at 10:30 conducted with the Irracknowledged the sh and dialysis storage cleaned or disinfecte On 09/23/08 at 2:30 Supervisor reported supervising houseke months ago. The Horacknowledged he did an oxygen storage roto store dialysis and could not confirm the areas were cleaned I Housekeeping Supernot know when the m cleaned by housekee Supervisor confirmed	erved floating in a pool of the washing machines. ocated off the 500 hall used intravenous supplies, trash of a trash can inside the ed the floor of the storage could be seen on IV supplies a bottom shelf approximately oor. In area under the lid of a own crumbs and dirt was erimeter and on top of the inside the washer. O AM, a tour of the facility was affection Control Nurse who nower room, clean linen room room were not properly	A	749			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		290042	B. WING		09/2	26/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	217	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 749	Continued From page	 e 113	A 749			
A 799	. •	and laundry rooms were ekeeping staff.	A 799			
	planning process that	ve in effect a discharge t applies to all patients. The d procedures must be				
	Based on interview, rand procedures revieensure policies and publisharge planning with facility failed to ensurincluded an evaluation services (A0808); fail implementation for the services (A0820); fail Health agencies (HH. that participated in the served the geographic resided (A0823); failed patient's medical record presented to the patient the patient's right to (A828); and failed to					
	·	ts of these systemic the failure of the facility to dated care to patients.				
	Findings include:					
	1. Policy review:					
	Section: Social Serv	ices: "Policy Discharge				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	ILITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 799	906 012.12, most re "Upon a receipt of re Director, Social Serv Planning document completion of the Dis Assessment Form, the Discharge Planning Services"; "Social Set Management informe process through mor weekly Discharge me Interdisciplinary Tear and via Social Service needed.". Another policy on dis provided (SS - 66, da other dates on policy members of the Inter (IDCP), will participal discharge plan for pa potential for discharge "the discharge plan is patient's/resident's ID in Social Services pro A Case Managemen (012.01CK with the re 9/99): "Interdiscipling weekly for the purpos reviewing the multi-d patients identified wit "team will sign an att Manager is specified leader/chairperson;" summarize the team Adjustment in the tre	dentation" (Standards Manual cent revision 5/05) - stated ferral from the Clinical ices will initiate Discharge ", "upon interview and upon scharge Planning The Case Manager will issue ing Referral form to Social ervices will keep Case and of discharge planning ming Discharge meetings, reetings/rounds, bi-weekly meetings/rounds, bi-weekly meetings/rounds, bi-weekly meetings (IDT) are chart documentation as accharge planning was ated original 3/2006 - no are ": "Social Services staff, as adisciplinary care plan team the in the development of a stients/residents with a ge to a private residence"; as incorporated into the DCP and addressed quarterly ogress notes. It policy was provided most recent revision dated any Team (ITM) meets se of developing and/or isciplinary care plan for the complex levels of care"; endance roster"; the Case	A 799			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
		290042	B. WIN	IG	 	09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 1170 EAST HARMON AVENUE LAS VEGAS, NV 89119	, 00/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 799	Care Plans revealed Case manager notes discharge. 3 On 9/23/08 in the most of Nursing (DON) and indicated the Case Manager notes documented only on those going into an atthose with an unsafe the above policies was procedures available. On 9/26/08 in the most (CM) confirmed the Case of CM conferred the above policies and procedures a	dance roster, nor a summary endations were provided. no discharge plan updates. did not indicate the patient's norning, the Acting Director d Social Worker (SW) lanager had the ultimate harge. The Social Worker cases referred to her (i.e. ssisted living situation or discharge). They conferred ere the only policies and for discharge planning. In ming, the Case Manager CM was the person ultimately scharge of a patient. The ove policies were the only res available for discharge Ited discharge planning was 10% Reviews". HOSPITAL SERVICES Ing evaluation must include ikelihood of a patient I services and of the		799			
	This STANDARD is	not met as evidenced by:					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		290042	B. WIN	IG		09/20	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION: TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
A 808	review the facility fails the needed post-hosp implementation of po arranged for 5 of 36 p. Findings include: 1. Patient #1 was add 12/28/08 and dischar The "Initial Admission Verification Form" da "Prior Living Arrange (lived with spouse); n written under "Prior Lunder "Anticipated Di The patient's record of needed post-hospi Case Manager (CM) The first, dated 12/31 waiting for her husba second, dated 1/8/08 regarding patients inf (social service referratives and eviden there was not a copy were there any Social The record contained "Interdisciplinary Patil Instructions". The 2 page 1s were different medications activity comments. N	document review, and record ed to ensure an evaluation of cital services and the initial st-hospital services were catients (#1, #2, #3, #4, #5) mitted to the facility on ged on 1/16/08. m/Discharge Demographic ted 12/28/07 contained: ments", only 1 box checked othing was checked nor evel of Functioning" nor scharge Plans" did not contain an evaluation tal services. There were 2 "Progress Notes" entries. /07, "patient confused. I am not to visit his wife"; the "12:00 spouse called formation - no response SSR all) sent." ce the referral was made as of the SSR in the chart nor I Services notes. 1 2 page 1s of the ent/Resident Discharge conflicting, they contained is diet orders and physical leither page 1s contained a 1 of the page 1s did not	A	808			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING	G		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	·	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 808	Continued From page	e 117	A	808			
	Discharge Instruction contain evidence that for the recommended health (HH), physical occupational therapy instructions did not signed on the recommendation of the recommendati	(OT) were made. The pecify if instructions were ended low salt diet. ed by the y that the instructions were she/they had the opportunity ed by the employee that the ven the instructions or a call if there were questions.					
		List" was not not completed admission nor discharge.					
	2. Patient #2 was addischarged on 9/1/07						
	A "Interdisciplinary P admit on 8/26/07. Th documented, regardi						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G		3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG		09/2	6/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHAB	ILITATION HOSPITAL	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 808	an evaluation of nee There were 2 progre Manager indicating w hospitalization (8/28/ indicating the patient home and the social arrangements. There was no docum of the referral to soci SW documentation. The "Patient's Effect discharge indicating her. Page 2 of the "Interd Discharge Instruction arrangements were i implementation of the were made. There was no docum arrangements were i the first appointment physician (PCP) as i Discharge Summary 1 week.	did not contain evidence of ded post-hospital services. ss note entries by the Case where the patient lived prior to 107) and the other on 9/1/07 was discharged to a group worker (SW) made the nented evidence in the record al services nor was there s List" was not signed at her glasses were returned to isciplinary Patient/Resident ns" did not contain evidence made for the initial e recommended HH services nented evidence made and the facility initiated with the primary care ndicated in the Physician's for follow-up with the PCP in	A	808				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) (X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING	3 <u></u>		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	1 00/2	572000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 808	Continued From page	e 119	A 8	808			
	"discharge to group health, nurse (RN), P	s dated 11/23/07 stated to nome (HIC) with home T, OT evaluation" ds for Home for Individual					
	The social services (sindicated the daughter placement for him in "Acknowledgement of completed by social states."	California. The f Referral" to be					
	There were no SS no	tes in the record.					
		ed "Physician's Report for ilities for the Elderly" for a sfield, California.					
	"Patient discharged to	dated 11/23/07 stated oday, he is going to (name of dome Health (HH) order."					
	Discharge Instruction instructions sheet did were given on the me	sciplinary Patient/Resident s" was not signed. The not specify if instructions edications or the green leafy vegetables					
	Discharge Instruction education was provid made for the initial im recommended HH; the the follow-up (in 3 da follow-up (in 1 week)	ys) with the PCP; nor the with the orthopedic.					
	Page 2 was not signe	ed by the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 808	explained to him and to ask questions. The "Patient's Effects nor signed at neither 4. Patient #4 was addischarged on 10/15. There was nothing do "Interdisciplinary Plair relating to Discharge The patient's record of needed post-hosp note dated 10/15/07 physician before cas see her 1200 noon". Page 1 of the "Interd Discharge Instruction information regarding for the initial impleme (PT) or occupational The instructions did r were given on the resoft diet with nectar the with feeding" diet. Page 2 of the "Interd Discharge Instruction There was no docum arrangements were rephysician (PCP) as in Discharge Summary	y that the instructions were he/they had the opportunity s List" was not not completed admission nor discharge. mitted on 10/11/07 and 707. commented in the patient's nof Care" (dated 10/11/07) planning. did not contain an evaluation ital services. A CM progress stated "Patient discharged by e management had time to disciplinary Patient/Resident ns" did not contain g if arrangements were made entation for physical therapy therapy (OT) were made. Not specify if instructions commended "mechanical hick liquids and assistance disciplinary Patient/Resident ns" was not in the record.	A	808			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		290042	B. WIN	IG		09/2	6/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 808	discharge indicating returned to her. 5. Patient #5 was ad 12/14/07 and dischard. There was nothing d "Interdisciplinary Pla relating to Discharge Page 1 of the "Interd Discharge Instruction tolerated". They did regarding if arrangen initial implementation occupational therapy. The Instructions were giv "2000 calorie America "2000 calorie America". The Cafurther documentation closed files. The Cafurther documentation available for the reviews Section: Social Serv Planning and Docum 906 012.12, most re "Upon a receipt of re Director, Social Serv Planning document completion of the Dis Assessment Form, the Discharge Planning to the section of the Discharge Planning contents of the Discharge Planning to the section of the Discharge Planning Planning to the section of the Discharge Planning to the section	mitted to the facility on reged on 12/18/07. cocumented in the patient's of Care" (dated 12/14/07) planning. isciplinary Patient/Resident of cocumented in formation of contain information was of contain information information was of contain		808			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL		2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 808	process through mo weekly Discharge m Interdisciplinary Tea and via Social Service needed.". Another policy on disprovided (SS - 66, dother dates on policy members of the Inte (IDCP), will participad discharge plan for potential for discharge plan in patient's/resident's lin Social Services post A Case Managemer (012.01CK with the 19/99): "Interdisciplin weekly for the purporeviewing the multi-copatients identified wi "team will sign an at Manager is specified leader/chairperson; summarize the team Adjustment in the treatted the anticipated dischlength of stay."	ed of discharge planning rning Discharge meetings, reetings/rounds, bi-weekly im Member meetings (IDT) ces chart documentation as scharge planning was ated original 3/2006 - no y): "Social Services staff, as rdisciplinary care plan team ate in the development of a atients/residents with a ge to a private residence"; is incorporated into the DCP and addressed quarterly rogress notes. In the policy was provided most recent revision dated fary Team (ITM) meets use of developing and/or disciplinary care plan for ith complex levels of care"; tendance roster"; the Case das the team "the ITM chairperson will it's recommendation for either: eatment plan; Adjustment in large plan; or continued	A	808			
A 820	of the ITM's recomm 482.43(c)(3) IMPLEI DISCHARGE PLAN The hospital must at		A	820			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		290042	B. WIN	NG_		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 820	Continued From page	e 123	A	820			
	Based on record revi failed to arrange for t	not met as evidenced by: ew and interview the facility he initial implementation and ent's discharge plan for 5 of #3, #4, #5).					
	1. Patient #1 was adı 12/28/07 and dischar	mittted to the facility on ged on 1/16/08.					
	made a referral to so specified in the CM n	ote. A copy of the SS tin the record nor were					
	· · · · · · · · · · · · · · · · · · ·	contained 2 page 1s of the ient/Resident Discharge					
	different medications orders and different p Neither page 1s cont	ined conflicting information: were listed; different diet physical activity comments. ained a resident number and not contain a patient name.					
	Discharge Instruction that arrangements we recommended imples (HH), physical therap therapy (OT). It did r were given on the recommended in the recommendation of the recommenda	mentation for home health by (PT) nor occupational not specify if instructions commended low salt diet.					
	l •	ed by the y that the instructions were she/they had the opportunity					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		290042	B. WIN	IG_		09/2	6/2008
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL		2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 820	patient/family was give telephone number to There was no docum arrangements were rephysician (PCP) as in Discharge Summary 1 week. 2. Patient #2 was add 8/26/07 and discharge A "Interdisciplinary Padmit on 8/26/07. The documented, regardi "Interdisciplinary Plant The patient's record an evaluation of need There were 2 progress indicating where the hospitalization (8/28/indicating the patient home and social servarrangements. There was no docum of the referral to social documentation. Page 2 of the "Interd Discharge Instruction education and arrangements arrangement arrange	ed by the employee that the ven the instructions or a call if there were questions. Idented evidence made with the primary care indicated in the Physician's for follow-up with the PCP in mitted to the facility on ged on 9/1/07. Idan of Care" was initiated at mere were no updates ing discharge, in the in of Care." Idid not contain evidence of ded post-hospital services. It is not entries by the CM patient lived prior to in o7) and the other on 9/1/07 was discharged to a group vices (SS) made the intented evidence in the record all services nor was there SS isciplinary Patient/Resident ins" did not contain evidence in the record isciplinary Patient/Resident ins" did not contain evidence in the recommended Home in of the recommended Home	A	820			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BL		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		290042	B. WING		09/	26/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	2.	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
A 820	initial appointment wi (PCP) as indicated in Summary for follow-us. 3. Patient #3 was add 10/31/07 and dischard "Interdisciplinary Planadmit on 10/31/07. Indocumented, regardi "Interdisciplinary Planadmit on 10/31/07. Indocumented, regardi "Interdisciplinary Planadmit on 10/31/07. Indocumented, regardi "Interdisciplinary Planadmit or Granadmit of Granad	nented evidence made were made for the ith the primary care physician in the Physician's Discharge up with the PCP in 1 week. mitted to the facility on rged on 11/23/07. In of Care" was initiated at There were no updates ing discharge, on the in of Care." Is dated 11/23/07 stated to home (HIC) with home PT, OT evaluation" Indicated the daughter was ent for him in California. The of Referral" 'to be services" is blank. In other was initiated indicated the daughter was ent for Home for Individual SS) referral form (initiated indicated the daughter was ent for him in California. The of Referral" 'to be services" is blank. In other was initiated indicated the daughter was ent for him in California. The of Referral" 'to be services" is blank. In other was initiated indicated the daughter was ent for him in California. The of Referral was initiated indicated the daughter was ent for him in California. The of Referral was initiated at indicated the daughter was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California. The of Referral was ent for him in California was ent for him i	A 820				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G		X3) DATE SURVEY COMPLETED	
		290042	B. WIN	IG _		09/2	6/2008	
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	1	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
A 820	regular" diet. Page 2 of the "Interd Discharge Instruction education was provid made for the initial in recommended HH; the follow-up (in 3 da follow-up (in 1 week) Page 2 was not signed patient/resident/famile explained to him and to ask questions. 4. Patient #4 was add 10/11/07 and dischard There was nothing do "Interdisciplinary Plater relating to Discharge The patient's record of needed post-hosp note dated 10/15/07 physician before cas see her 1200 noon". Page 1 of the "Interd Discharge Instruction information regarding for the initial implement (PT) or occupational The instructions did in were given on the residence in the instructions did in were given on the residence in the instructions did in were given on the residence in the instructions did in were given on the residence in the instructions did in the instruction of the instruction o	edications or the digreen leafy vegetables disciplinary Patient/Resident as did not contain evidence if ded and arrangements were applementation of the ne 24 hour nursing hotline; and by the PCP; nor the with the orthopedic. The did by the yethat the instructions were he/they had the opportunity did not contain an evaluation of the patient's and of Care" (dated 10/11/07) planning. The did not contain an evaluation of the patient discharged by the management had time to disciplinary Patient/Resident	A	820				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		290042	B. WIN	1G _		09/2	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL		:	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 820	Continued From page	e 127	А	820			
		isciplinary Patient/Resident is was not in the record.					
	physician (PCP) as ir Discharge Summary	nented evidence made with the primary care indicated in the Physician's for the initial implementation the PCP in 2 weeks.					
	5. Patient #5 was add 12/14/07 and dischar	mitted to the facility on ged on 12/18/07.					
		ocumented in the patient's n of Care" (dated 12/14/07) planning.					
	Discharge Instruction tolerated". It did not education and the are	isciplinary Patient/Resident ns" documented "PT, OT as contain information regarding rangements for the initial hysical therapy (PT) or (OT).					
		fy if instructions were given d "2000 calorie American					
	checked the closed r further documentatio closed records. The further documentatio	erning, the Case Manager, ecords and the computer for n on the reviewed sampled Case Manager indicated no n or information was ewed sampled closed					
		ndicated the facility utilized 1 for post-hospital care and of HHA providers.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SUF COMPLET	
		290042	B. WIN	IG		09/2	6/2008
	OVIDER OR SUPPLIER	ILITATION HOSPITAL	•	2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE S VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 820	Continued From pag	e 128	А	820			
A 823	appointment with the reported she faxed a gave the patient the Case Manager indica responsibility of the Hensure an appointmed 482.43(c)(6) LIST OF AGENCIES The hospital must include the first of (HHAs or) SNE patient, that are partiprogram, and (that sedefined by the HHA) or) in the case of a State of the first o	HHA and/or the patient to ent. HHA and/or the patient to the cipating in the Medicare erve the geographic area (as in which the patient resides, SNF, in the geographic area ient. (HHAs must request to	A	823			
	Based on interview, review the facility fail health agencies (HH. the discharge plan, for post-hospital service #3). Findings include: Three of the 5 Close health as a recommendate There was no evident list of possible Medical. Patient #1 was ad 12/28/07 and discharge.	mitted to the facility on rged on 1/16/08.					
	The Physicians Disc	harge Summary (10/16/08)					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		290042	B. WING _		09/	26/2008
	ROVIDER OR SUPPLIER	LITATION HOSPITAL	รา	TREET ADDRESS, CITY, STATE, ZIP COI 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 823	Page 2 of the "Interdict Discharge Instruction contain evidence a list agencies was provided. There was no docume Progress Notes a list the patient. 2. Patient #2 was add 8/26/07 and discharge Page 2 of the "Interdict Discharge Instruction the "Notifications/Arradischarge". There was a list of HH agencies. There was no docume Progress Notes a list the patient. 3. Patient #3 was add 10/31/07 and discharge to group in the physician Orders "discharge to group in the physician orders and the patient of the group in the physician orders and the patient discharged to group in the physician orders and the progress note in the group home) with the group home with the group home) with the group home with the group	isciplinary Patient/Resident is was not signed. It did not st of home health (HH) ed. ented evidence in the of HHAs was provided to mitted to the facility on led on 9/1/07. isciplinary Patient/Resident is listed home Health under langements, made before as no documented evidence was provided. ented evidence in the of HHAs was provided to mitted to the facility on ged on 11/23/07.	A 82	3		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SUI COMPLET	
		290042	B. WIN	G		09/2	6/2008
	ROVIDER OR SUPPLIER	SILITATION HOSPITAL	•	217	ET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE IS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 823	the patient. Page 2 of the "Interd Discharge Instruction list of HH agencies with the Discharge Plan facility provided were 1. Section: Social Stranger Planning and Docum 906 012.12, most re 2. "SS - 66", dated dates on policy; 3. 012.01CK with the 9/99). None of the policies making available an planning process a I HHAs or SNFs (skill providers. On 9/24/08 at 2:00 F Nursing (DON) and the Case Manager h	disciplinary Patient/Resident ns" did not contain evidence a was provided. Policies and Procedures the e: Services: "Policy Discharge nentation" (Standards Manual ecent revision 5/05); original 3/2006 - no other are most recent revision dated included procedures for d included in the discharge ist of participating Medicare ed nursing facilities) PM, the Acting Director of Social Worker (SW) indicated and the ultimate responsibility	A	823	DEFICIENCITY		
	only on cases referran assisted living sit unsafe discharge). I policies were the on available for dischar On 9/26/08 in the m (CM), confirmed the responsible for the case Manager confi	orning, the Case Manager CM was ultimately lischarge of a client. The irmed the above listed policies and procedures available					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		290042	B. WIN	1G		09/20	6/2008
	OVIDER OR SUPPLIER	LITATION HOSPITAL	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 823	Continued From pag	e 131	A	823			
A 827	home health agency did not provide a list Manager indicated a nor a list of SNF were Manager indicated the part of the discharge. The CM reported she appointment with the reported she faxed a gave the patient the Case Manager indicates an appointment with the resure an appointment with the ensure and appointment with the en	e did not make the the HHA. The Case Manager referral to the agency and HHA telephone number. The ated it was then the HHA and/or the patient to ent. CHARGE PLANNING Coument in the patient's he list was presented to the ridual acting on the patient's was and interview the hospital a list of home health nursing facilities was nt or to the individual acting lf for 3 of 36 patients (#1, #2, mitted to the facility on	A	827			
	siaicu liaiisielleu	to a group nome with nome					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	290042		B. WIN	IG		09/26/2008		
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL				2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
A 827	Discharge Instruction contain documented health (HH) agencies There was no docum Progress Notes a list the patient. 2. Patient #2 was add 8/26/07 and discharge Page 2 of the "Interd Discharge Instruction the "Notifications/Arradischarge". There was a list of HH agencies There was no docum Progress Notes a list the patient. 3. Patient #3 was add 10/31/07 and discharge to group the health, nurse (RN), poccupational therapy Clarification HIC star Care. A CM progress note "Patient discharged to group home) with Ho	isciplinary Patient/Resident is was not signed. It did not evidence a list of home is was provided. Idented evidence in the inf HHAs was provided to mitted to the facility on isciplinary Patient/Resident is listed home Health under angements, made before as no documented evidence was provided. Idented evidence in the inf HHAs was provided to mitted to the facility on iged on 11/23/07. In the facility on iged on 11/23/07 stated to income (HIC) with home inhysical therapy (PT),	A	827				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
290042		B. WIN	IG_		09/26/2008		
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL				2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE ILATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE		
A 827	the patient. Page 2 of the "Interd Discharge Instruction list of HH agencies von The Discharge Plan facility provided were Services: "Policy Discharge Plan for 13/2006 - no 0012.01CK with the man for 13/2006 - no 0012.01CK with the man facility of participating (skilled nursing facility of the patient or the pehalf prior to discharge (Skilled nursing facility of the patient or the pehalf prior to discharge (DON) and State Case Manager has sisted living situnsafe discharge). The solicies were the online available for discharge (CM) confirmed the Cresponsible for the discharge Manager confirmed the Cresponsible for the discharge Manager confirmed the Case Manager confirmed the Cas	isciplinary Patient/Resident ns" did not contain evidence a vas provided. Policies and Procedures the e: 1). Section: Social scharge Planning and undards Manual 906 012.12, 5/05); 2). "SS - 66", dated other dates on policy; 3). nost recent revision dated included procedures for ng, in the medical record, that Medicare HHAs or SNFs ties) providers was provided person acting on the patient's arge. PM, the Acting Director of Social Worker (SW) indicated ad the ultimate responsibility social Worker documented ed to her (i.e. those going into unation or those with an they confirmed the above by policies and procedures ge planning. Prining, the Case Manager CM was ultimately ischarge of a client. The rmed the above listed policies s and procedures available	A	827			

1, 7		I ' '			(X3) DATE SURVEY COMPLETED	
290042 B. WING			09/26/2008			
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			2	2170 EAST HARMON AVENUE	1 00/2	572000
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					LD BE	(X5) COMPLETION DATE
Continued From page	e 134	A	827			
provide a list of HH a The Case Manager in was not a part of the The Case Manager in home health agency did not provide a list. Manager indicated th part of the discharge The CM reported she appointment with the faxed a referral to the patient the HHA telep indicated it was then and/or the patient to made. 482.43(c)(7) FREED FACILITIES The hospital, as part process, must inform family of their freedor participating Medicar care services, and This STANDARD is Based on record revi failed to, as part of th process, inform the p of their freedom to ch Medicare providers of for 3 of 36 patients (# Findings include:	gencies nor a list of SNF. Indicated the list of providers discharge planning process. Indicated the facility utilized 1 for post-hospital care and of HHA providers. The Case is list of providers was not a planning process. Indicated the facility utilized 1 for post-hospital care and of HHA providers. The Case is list of providers was not a planning process. Indicated the facility utilized 1 for post-hospital care services in the patient of the Case is a planning attent or the patient's family process among participating of post-hospital care services in the post-hospital care services in the post-hospital care services in the patient or the patient's family process among participating of post-hospital care services in the post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient's family process among participating of post-hospital care services in the patient in	A	828			
1. Patient #1 was adı	mitted to the facility on					
	COVIDER OR SUPPLIER MEDICAL AND REHABI SUMMARY ST (EACH DEFICIENC REGULATORY OR) Continued From page The Case Manager ir provide a list of HH a The Case Manager ir was not a part of the The Case Manager ir home health agency did not provide a list of Manager indicated th part of the discharge The CM reported she appointment with the faxed a referral to the patient the HHA telep indicated it was then and/or the patient to or made. 482.43(c)(7) FREEDO FACILITIES The hospital, as part process, must inform family of their freedor participating Medicare care services, and This STANDARD is Based on record revir failed to, as part of th process, inform the p of their freedom to ch Medicare providers o for 3 of 36 patients (# Findings include:	TOORIECTION DENTIFICATION NUMBER: 290042 DOVIDER OR SUPPLIER MEDICAL AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 134 The Case Manager indicated the facility did not provide a list of HH agencies nor a list of SNF. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The Case Manager indicated the list of providers was not a part of the discharge planning process. The CM reported she did not make the the appointment with the HHA. The CM reported she faxed a referral to the agency and gave the patient the HHA telephone number. The CM indicated it was then the responsibility of the HHA and/or the patient to ensure an appointment was made. 482.43(c)(7) FREEDOM TO CHOOSE FACILITIES The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services, and This STANDARD is not met as evidenced by: Based on record review and interview the hospital failed to, as part of the discharge planning process, inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services for 3 of 36 patients (#1, #2, #3).	A BUILDING AND REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 134 The Case Manager indicated the facility did not provide a list of HH agencies nor a list of SNF. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The Case Manager indicated the list of providers was not a part of the discharge planning process. The CM reported she did not make the the appointment with the HHA. The CM reported she faxed a referral to the agency and gave the patient the HHA telephone number. 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Findings include:	CONTRECTION IDENTIFICATION NUMBER: 290042 STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	CONFIGER OR SUPPLIER 290042 STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119 SUMMARY STATEMENT OF DEFCIENCIES (EACH DEFCIENCIES SIPPLINE REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 134 The Case Manager indicated the facility did not provide a list of HH agencies nor a list of SNF. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Chase Manager indicated the list of providers was not a part of the discharge planning process. The Chase Manager indicated the list of providers was not a part of the discharge planning process, usual inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services or 3 of 36 patients (#1, #2, #3). Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
290042		B. WIN	G		09/26/2008		
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			2170	T ADDRESS, CITY, STATE, ZIP CODE DEAST HARMON AVENUE S VEGAS, NV 89119			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
stated " transferred to health follow-up" Page 2 of the "Interdisc Discharge Instructions' contain documented exhealth (HH) agencies of the patient. There was no documented exhealth (HH) agencies of the patient. Page 2 of the "Interdisc Discharge Instructions' the "Notifications/Arrandischarge". There was a list of HH agencies of the patient. There was no documented by the patient. Page 2 of the "Interdisc Discharge Instructions' the "Notifications of the patient of the patient. There was no documented by the patient. Progress Notes a list of the patient. Progress Notes a list of the patient. Progress Notes a list of the patient. The physician Orders of "discharge to group hothealth, nurse (RN), physician of the physician of th	rge Summary (10/16/08) of a group home with home ciplinary Patient/Resident was not signed. It did not widence a list of home was provided. Inted evidence in the final that was provided to tited to the facility on do n 9/1/07. Ciplinary Patient/Resident listed home Health under gements, made before an odocumented evidence was provided. Inted evidence in the final that was provided to tited to the facility on ed on 11/23/07. Cidated 11/23/07 stated to me (HIC) with home visical therapy (PT), DT) evaluation" Is for Home for Individual	A	828				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
290042		B. WING		09/26/2008	
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABI	LITATION HOSPITAL	2	REET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE .AS VEGAS, NV 89119		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
group home) with Ho There was no docum Progress Notes a list the patient. Page 2 of the "Interdi Discharge Instruction list of HH agencies w The Discharge Plan I facility provided were 1. Section: Social S Planning and Docum 906 012.12, most re 2. "SS - 66", dated o dates on policy; 3. 012.01CK with the 9/99). None of the policies i of the discharge plan the facility informed the acting on the patient's freedom to choose for On 9/26/08 in the mo (CM) indicated the Ch discharge of a client, above listed policies i procedures available The Case Manager in provide a list of HH a Nursing Facilities (SN	oday, he is going to (name of ome Health (HH) order." lented evidence in the of HHAs was provided to disciplinary Patient/Resident are provided. Policies and Procedures the experience in the evidence and procedures the experience in the evidence in the evidence and procedures the experience in the evidence in the e	A 828			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WING			09/26/2008	
	OVIDER OR SUPPLIER	LITATION HOSPITAL	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 170 EAST HARMON AVENUE AS VEGAS, NV 89119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		.D BE	(X5) COMPLETION DATE
A 828 A 830	home health agency to did not provide a list of indicated the list of pr discharge planning pr	ndicated the facility utilized 1 for post-hospital care and of HHA providers. The CM roviders was not a part of the		828			
	The hospital must not the qualified providers patient. This STANDARD is reasonable by Based on policy review hospital failed to ensure the statement of the st	t specify or otherwise limit is that are available to the not met as evidenced by: we and interviews the ure they did not specify or alified providers that were					
	facility provided were 1. Section: Social Se Planning and Docume 906 012.12, most red 2, "SS - 66", dated or dates on policy; 3. 012.01CK with the 9/99). None of the policies in	ervices: "Policy Discharge entation" (Standards Manual					
	qualified providers av post-hospital care. On 9/24/08 at 2:00 PI Nursing (DON) and S the above policies we	M, the Acting Director of social Worker (SW) indicated for discharge planning.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		290042	B. WING			09/26/2008	
	OVIDER OR SUPPLIER MEDICAL AND REHABII		1	2	REET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119	1 09/20	6/2006
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 830	Continued From page	e 138	A 830				
A 885	confirmed the CM was the discharge of a clie above listed policies of procedures available. The CM indicated the of HH agencies nor a Facilities (SNF). The providers was not a process. The CM indicated the	rning, the Case Manager s ultimately responsible for ent. The CM confirmed the were the only policies and for discharge planning. I facility did not provide a list list of Skilled Nursing CM indicated the list of eart of the discharge planning I facility refers all patients to cy. Only one provider was	A	885			
A 887	protocols that: This STANDARD is a Based on policy and administrator interview incorporate an agreed procurement organization. Findings include: On 9/24/08 at 11:00 A Administrator reporte written agreement with organization (OPO). 482.45(a)(2) TISSUE AGREEMENTS Incorporate an agreed	w the facility failed to ment with an organ ation (OPO). AM, the Hospital d the facility did not have a ch an organ procurement AND EYE BANK ment with at least one tissue	A	887			
		e eye bank to cooperate in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 290042			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WIN	G		09/26/2008			
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			•	217	ET ADDRESS, CITY, STATE, ZIP CODE O EAST HARMON AVENUE S VEGAS, NV 89119	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)		OULD BE	(X5) COMPLETION DATE	
A 891	and distribution of tis appropriate to assureyes are obtained from as such an agreement organ procurement; This STANDARD is Based on an interview administrator, the facility administrator, the facility did not have been procurement of any procurement process. Findings include: Review of the facility "Organ Tissue, Eye revised 9/06 revealed be aware of the gend donation and activel procurement process.	sing, preservation, storage sues and eyes, as may be e that all usable tissues and om potential donors, insofar ent does not interfere with not met as evidenced by: ew with the hospital cility failed to have an tissue and one eye bank. Dital administrator reported ave an agreement with an organization providing tissue als. EDUCATION Dital works cooperatively with the tissue bank and eye bank in conation issues; not met as evidenced by: procedure review and staff failed to educate the hospital in, tissue and eye donation of policy and procedure entitled And/Or Cornea Donation " d " All Nursing Personnel will eral criteria for cadaver organ y participate in the		887				
		narge Nurse did not know if						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING				
		290042			09/	26/2008	
	ROVIDER OR SUPPLIER MEDICAL AND REHABI	LITATION HOSPITAL	21	EET ADDRESS, CITY, STATE, ZIP CODE 70 EAST HARMON AVENUE AS VEGAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		(X5) COMPLETION DATE	
A 891	and did not know whi regarding organ procedid not know how she donor. On 9/22/08, Charge I The Charge Nurse we admission interview fregarding organ dona reported the form ent Authorization " contanurse had to indicate service was notified a organ or tissue donor she did not know if in to call an organ procedure that a procurement. On 9/22/08, the Insert #4, was interviewed. the organ procurement the nurses were not forced.	dressing organ procurement at her responsibilities were urement. The Charge Nurse a could tell if a patient was a sware the nursing form contained a question ation. The Charge Nurse itled "Release of Body sined a section where the if an organ service recovery and if the patient was an areason urement organization. The charge Nurse stated minent death was a reason urement organization. The ot know if there was a policy ddressed organ Evice/Infection Control Nurse The nurse was not aware of an as part of their orientation	A 891				
	#4, was interviewed. the organ procureme the nurses were not t tissue or eye donatio	The nurse was not aware of nt policy. The nurse reported rained in regard to organ, n as part of their orientation					